



## REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Please tell us what protected health information you want changed:

\_\_\_\_\_  
\_\_\_\_\_

Please tell us why you want this change. You must give a reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AHS must notify you within 60 days if we will change your protected health information as you requested or tell you that we need more time (up to 30 extra days) to decide.

**Please tell us where to send you a letter:**

**Where to phone you:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If we decide to change the health information as you requested, we will send the change to any person or agency who received the information before it was changed. Please tell us if there are any such persons or agencies who need the changed information.

\_\_\_\_\_ No, there are no such persons or agencies  
\_\_\_\_\_ Yes, please notify these persons at these addresses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

\_\_\_\_\_ Yes Initials \_\_\_\_\_ \_\_\_\_\_ No Initials \_\_\_\_\_

We do not have to change your protected health information if:

1. We did not create the information, unless the person/agency who created the information is unavailable to act on your request (for example, the doctor who originally created the information has died). If this exception applied to you, please explain below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. The information is complete or accurate.
3. You do not have the legal right to access the information you want to be changed.
4. The information you want changed is not part of the designated record set. The designated record set is your medical, billing and other records we use to make decisions about your care.

\_\_\_\_\_  
Signature of patient or representative

\_\_\_\_\_  
If representative, give relationship

**Mail to: Director of Compliance, Axis Health System, 185 Suttle St., Durango, CO 81303.**

For more information about your privacy rights, please see the Notice of Privacy Practices, available on the website at [www.axishealthsystem.org](http://www.axishealthsystem.org) or from the Director of Compliance. If you believe your privacy rights have been violated, you may file a complaint with the AHS' Grievance Coordinator, PO Box 1328, Durango, CO, 81302, or with the Secretary of the Department of Health and Human Services.