Request to Amend a Record

This form is used for an Individual to request an amendment to their protected health information (PHI). An Individual has the right to have a HealthTrust amend protected health information (PHI) or a record about the Individual in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set. A "designated record set" is a group of records maintained by or for HealthTrust that is 1) the medical records and billing records about individuals maintained by or for a covered health care provider; 2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3) used, in whole or in part, by or for HealthTrust. to make decisions about Individuals. Record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for HealthTrust. (45 CFR § 164.526).

I request HealthTrust to amend the protected health information in its designated record set as described and justified below. (Please use the back of this form if additional space is required).

Specific Statement of Amendment Request:
Specific Reason for Amendment Request:

By signing this form,

- I understand that HealthTrust has 60 days to respond to this request.
- I understand that if the protected health information was not created by HealthTrust, HealthTrust is not required to honor my request. For example, if the information I wish to amend is in a medical report created by my physician, I must ask the physician - not HealthTrust - to amend the report.
- I understand that if the information is not available for my inspection, is not part of HealthTrust's designated record set, or is already accurate and complete, I cannot amend the information.

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER Reference: HIPAA Individual Rights Policy.	
Name of HealthTrust Workforce Member Receiving Form:	Date: