HONORHEALTH

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# REQUEST FOR AMENDMENT OF HEALTH INFORMATION

**Network Support Services (NSSC)**
**Attn: Health Information Management Release of Information**
**2500 W. Utopia, Phoenix, AZ 85027**
**Phone: (480) 882-4040**
**FAX: (480) 882-5841**

❑ **For NOAH Clinics please mail to appropriate location** ❑ **For HonorHealth Medical Groups send to the above address**

## PATIENT IDENTIFYING INFORMATION:

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

NAME OF REPORT(S) YOU WANT CHANGED: _____
DATE OF SERVICE(S) WHEN REPORT WAS CREATED: _____
DESCRIBE WHAT PART(S) OF THE REPORT NEEDS TO BE CHANGED: _____
_____
_____
_____
_____
_____

IN YOU OPINION, WHAT SHOULD THE REPORT SAY TO BE MORE ACCURATE OR COMPLETE AND WHY: (please provide enough information to support your request for amendment, i.e., eyewitness accounts that support your request, additional medical records from your doctors, etc.

_____
_____
_____

If your request to the amendment is granted, would you like this information sent to anyone whom we may have disclosed the information in the past? If so, please specify the name(s) and address(es) below.
**Attach a form indicating additional names and addresses.**

| Name of Person or entity | Address | Disclosure Date |
|---|---|---|
| | | |
| | | |

I understand that I may receive a copy of this form and that my request will be processed within 60 days. I understand I will be informed if an extension of not more than 30 additional days is needed to process this request.

I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement of disagreement; or if I do not submit a written statement of disagreement, I understand that I may ask that my request for amendment and the denial be disclosed with any future disclosures of the information that is the subject of the amendment. My statement of disagreement or request for this disclosure should be in writing to The Health Information Management Departments at any of the HonorHealth facilities listed above.

I understand that I may file a complaint concerning my request for amendment within 180 days of making the request to the person listed above. I may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/ Patient Representative Relationship to the patient and your authority to act for the patient (please attach evidence if appropriate)