HonorHealth.com

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

❑**Scottsdale Osborn Medical Center**	❑**Scottsdale Shea Medical Center**	❑**John C. Lincoln Medical Center**	❑**Deer Valley Medical Center**
Health Information Management	Health Information Management	Health Information Management	Health Information Management
7301 E. Fourth St., Ste 10	9003 E. Shea	250 E. Dunlap Ave.	19829 N. 27th Ave.
Scottsdale, AZ 85251-6403	Scottsdale, AZ 85260	Phoenix AZ 85020	Phoenix, AZ 85027
(480) 882-4040	(480) 323-3213	(602) 870-6352	(623) 879-5571
FAX: (480) 882-5841	FAX: (480) 882-5841	FAX: (602) 678-3217	FAX: (623) 879-5559

❑ **For Scottsdale Thompson Peak Medical Center Requests please mail your requests to the Scottsdale Shea Medical Center Campus**

❑ **For Sonoran Health and Emergency Center requests, please mail your requests to the Deer Valley Medical Center Campus**

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: ______________________________

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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.

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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)