## REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Pat	tient's Name:	Last	First	 Middle	Date of Birth						
Home Address:			1 1130	,	)						
Email Address:					Home Phone						
I hereby request that City of Hope National Medical Center amend <b>[please check all boxes that apply]:</b>											
All as more specifically described below:											
I understand that City of Hope National Medical Center may deny this request as permitted under law. I further understand that if City of Hope National Medical Center denies my request, I will be informed in writing by City of Hope National Medical Center of its reason for the denial and what I should do if I disagree with the denial. I further understand that City of Hope National Medical Center will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If City of Hope National Medical Center is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.  1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results).											
1.	ysician notes, test rest										
2.	Date(s) of information to be amended (e.g., date of office visit, physician note, treatment).										
3.	How is the er	How is the entry incorrect, incomplete, or outdated?									
4.	What should	/hat should the entry say to be more accurate or complete? (Please be as specific as possible)									
5.	How was this	How was this information discovered? (e.g., from patient portal, medical records received)									
6.	Do you know of anyone who may have received or relied on the information in question (such as: your doctor, pharmacist, health plan, or other health care provider)?   Yes  No  If yes, please specify the name(s) and address(es) of the organizations or individual(s):										
PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME		ED NAME SIGNATU	SIGNATURE		TIME						
If Personal Representative has signed above, please indicate your relationship to the patient:											
□ Parent □ Guardian □ Conservator □ Agent □ Other											
City of Hope National Medical Center 1500 East Duarte Road, Duarte, CA 91010											
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION											

Form No. 8610-C029 Revised: 03/13/20 Reviewed: 03/13/20 RAPHI Photocopy: Patient Page 1 of 2

## REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

## FOR CITY OF HOPE NATIONAL MEDICAL CENTER USE ONLY

Amendment has been:   Accepted  Request communicated with the appropri  If denied, check the reason for denial:	□ Denie iate physician										
☐ Protected Health Information was not created by City of Hope National Medical Center.											
<ul> <li>Protected Health Information is not accessible by the patient under City of Hope National Medical Center's policy regarding the patient's right to access his or her Protected Health Information.</li> </ul>											
☐ Protected Health Information is accurate and complete.											
Comments:											
COHNMC REPRESENTATIVE PRINTED NAME	SIGNATURE		TITLE	DATE	TIME						
City of Hope National Medical Ce 1500 East Duarte Road, Duarte, CA 910 REQUEST FOR AMENDMENT OF PRO HEALTH INFORMATION	10										

Form No. 8610-C029 Revised: 03/13/20 Reviewed: 03/13/20 RAPHI Photocopy: Patient Page 2 of 2