REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City/State/Zip Code: _____

Date of Birth: _____ Preferred Telephone: (____) _____ ☑Mobile ☑Home ☑Work ☑Other

Email Address: _____

I hereby request that City of Hope amend **[please check all boxes that apply]:**

☐ My medical records ☐ My billing records

All as more specifically described below:

I understand that City of Hope may deny this request as permitted under law. I further understand that if City of Hope denies my request, I will be informed in writing by City of Hope of its reason for the denial and what I should do if I disagree with the denial. I further understand that City of Hope will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If City of Hope 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).

_____

_____

2. Date(s) of information to be amended (e.g., date of office visit, physician note, treatment).

_____

_____

3. What is your reason for making this request? _____

_____

4. How is the entry incorrect, incomplete, or outdated? _____

_____

5. 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	SIGNATURE	DATE	TIME

If Personal Representative has signed above, please indicate your relationship to the patient:

☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other

City of Hope

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How to Submit Form:
Once completed, please forward to the Health Information Management Service Department using one of the following methods:

COH - California

- Email: himsroi@coh.org
- Fax: (626) 218-8443, Attention: Health Information Management Services (ROI)
- Mail:

  Health Information Management Services (ROI)
  City of Hope
  1500 East Duarte Road
  Duarte, CA 91010

COH - Chicago, Atlanta, Phoenix, Hospitals and Outpatient Care Centers

- Email: himsroi2@coh.org
- Fax: (847) 746-6791, Attention: Health Information Management Services (ROI)
- Mail:

  Health Information Management Services (ROI)
  City of Hope
  2520 Elisha Ave
  Zion, IL 60099