Lancaster Behavioral Health Hospital

Penn Medicine Lancaster General Health | UHS

333 Harrisburg Ave, Lancaster, PA 17603
Phone: 717-740-4026 Fax: 717-740-4063

REQUEST TO AMEND PHI

Name: _____
(Last) (First) (M.I.)

Address: _____
(Street) (City) (State) (Zip Code)

Telephone #: _____ **Date of Birth:** _____ **Last 4 digits of SS#:** _____

Please tell us what protected health information (PHI) you want changed (use back of page or additional pages if necessary):

_____

Please tell us why you want to make this amendment to your health record (use back of page or additional pages if necessary):

_____

We must tell you within 60 days if we will change your PHI as you requested, or tell you that we need more time (up to 30 additional days) to decide.

Please tell us where to send you a letter if different from above:
Address: _____

Available hours to inspect your protected health information are Monday through Friday, 8:00 a.m. to 4:00 p.m.
*There will be reasonable clerical fees charged for any inspection of the designated record set as authorized by STATE Law and posted in the Health Information Management Department (Medical Records).

If we decide to change the PHI as you requested, we will send the change, upon request, to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information. If you need an accounting of the disclosures that have been made we will be happy to provide you with one.

* Yes. Please list names and addresses: _____

_____

* No. Please Initial Here: _____

We do not have to change your PHI if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   _____

2. The information is accurate and complete.
3. You do not have the legal right to access the PHI you want changed.
4. The PHI you want changed is not part of the designated record set.

If the change is denied we will inform you of the decision and the necessary steps for you to submit a written statement of disagreement.

Date: _____
Signature of Patient or Legal Representative: _____
If Legal Representative, state relationship and attach documentation: _____

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.lancasterbehavioral.org.

THIS SECTION WILL BE COMPLETED BY THE REVIEWER

Date Received: _____ Received By: _____
Decision: _____ Reviewed By: _____
Notes Regarding Decision: _____

Return form to the Health Information Management Dept.