CHILDREN'S OF ALABAMA
REQUEST FOR AMENDMENT OF
PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: (Please print)		Request Date:	
Street Address City/State/Zip:		Birth Date:	
Phone Number to be Reached:		Date of Service:	

Request for Amendment

Information to be Reviewed:		Date of Information:	
Reason for Review:			
What the information should state to be more accurate or complete:			
Do you know of anyone who may have received this information in the past? (i.e., doctor, insurance company)	NO ☐	YES ☐	If yes, who? Please provide name(s) and address(es):

Signature of Parent/Legal Guardian/Patient

I represent that I am the parent/legal guardian/patient and have the authority to request this amendment. I understand that Children's may not be able to accept this amendment if prohibited by law. Children's is not permitted to alter the original medical record. This request will be made a part of the patient's medical record.

Parent/Legal Guardian Signature :_____Date:_____

Patient Signature if 14 or older:_____Date:_____

Witness Signature:_____Date:_____

INTERNAL USE ONLY: Date Received:_____ Accepted Denied

Comments:_____ MIS Initials:_____HIPAA Initials:_____