Banner Health®

REQUEST TO AMEND OR SUPPLEMENT RECORDS

Please fill in the following information:

1. Patient Name: _____ 2. Birth Date: _____
3. Medical Record #: _____ 4. Facility: _____
5. Patient Address: _____
6. Date(s) of information to be amended (e.g., date of office visit, treatment or other health care services):

   _____
7. Describe the information you want amended/supplemented (e.g., history & physical, physician notes):

   _____
8. Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (Use additional sheets if needed and attach to this form): _____

   _____

   _____

   _____

   _____

   With your permission, Banner Health facilities will make their best efforts to notify persons or organizations who may have received all or part of your record.
9. Would you like this amendment sent to anyone who received the information in the past? ❑ Yes ❑ No
   If yes, please specify the name(s) and address(es) of the organization(s) or individual(s): _____

   _____

   _____

I understand that my request will be considered, but may not be granted if Banner Health determines that my protected health information (PHI) or record that is subject to this request was:
Not created by Banner Health or its business associates; Is not part of my medical or billing record; Would not be available for me for inspection under applicable law dealing with access to protected health information; Or is accurate or complete.

I have read the above and understand my right to request to amend or supplement my records. I hereby request that Banner Health add this amendment/supplement to my records and authorized Banner Health to notify other persons or organizations I have listed above, and to notify persons or organizations identified by Banner Health to notify other persons or organizations I have listed above, and to notify persons or organizations identified by Banner Health.

_____ _____

Signature of Patient or Legally Authorized Representative | Date

_____ _____

Print Name | Relationship to Patient

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For Internal Use Only:

Date Received: _____

❑ Your request has been granted and an amendment/supplement will be made to your permanent record

❑ This request for amendment has been made part of your permanent record; however, your request to amend your health record directly has been denied for the following reason(s):

_____ PHI not created by this organization _____ PHI is not part of the patient's health record _____ PHI is accurate and complete

_____ PHI is not available to the patient for inspection as required by law (e.g. psychotherapy notes)

Comments: _____

_____

Initials/Lawson: _____ Date of Review: _____

Instructions for Completing REQUEST TO AMEND OR SUPPLEMENT RECORDS Form

1. Print legibly in all fields using dark permanent ink.
2. Sign and date the request.
3. Submit the completed and signed form to the applicable department (HIMS/HIPAA Facility Contact or the Business Office).
4. You will receive a photocopy of your completed form, as an acknowledgement of receipt of your request, no later than 10 business days after Banner Health (BH) receives your request.
5. You will be notified of the acceptance or denial of your request.
6. If you agree to allow BH to release any amended information and if your request to amend is accepted:
    a. BH will make their best efforts to send any amended or corrected information to anyone who BH knows received this information in the past and who may have relied, or is likely to rely, on such information to your detriment.
    b. BH will make their best efforts to send the correction or amendment to those individuals or entities/ organizations you identify and who have a need for the correction or amendment.
7. If your request is denied, you may do the following:
    a. Submit to the applicable department (HIMS/HIPAA Facility Contact or the Business Office) a one page written statement disagreeing with the denial and the basis of such disagreement.
    b. If you do not submit a statement of disagreement, you may request that BH provide this request for correction or amendment (or summary) and the denial with any future disclosures.
    c. BH has the right to prepare a written rebuttal to any statement of disagreement. You will be provided a copy of any rebuttal statement. Any written rebuttal prepared by BH is not subject to correction or amendment.
8. If you have a complaint about BH policies and procedures regarding health information, you may file such a complaint with Patient Relations/Administration by calling our main switchboard at 602-747-4000 and they will direct your call to the appropriate facility; the Department of Health and Human Services, Office for Civil Rights, we will provide you with the address upon request.
9. This form and subsequent information pertaining to this request will become part of your permanent health record.
10. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint.

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(03/2017)