Premier Health

Premier Physician Network

Patient Request for Amendment to Health Information

You have the right to request Premier Physician Network to make corrections or amendments to the health information we retain on your behalf if you believe something in that information is in error or needs to be amended.

We are not always required to make the corrections or amendments you request. Each request will be carefully reviewed. Corrections or amendments will be made, if warranted.

You will be notified when your request has been approved or denied unless you have either not signed the form or have not provided a reason for the requested corrective or change.

Patient Name	Date of Birth
Postal Address to receive notice (include Address, City, State, and Zip Code)	
Phone no.	

Instructions:
1. On another sheet of paper, please provide as much detail as possible regarding the correction or amendment you seek in your medical information. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "my laboratory test results from ABC laboratory of December 5, 2000, show a blood test I never received" or "Dr. Jones in your North Street Clinic recorded in my record on December 5, 2000, that I was suffering from weakness in my right leg when in fact the weakness is in my left leg." To review the requested correction, we must be able to locate the record in issue and the exact entries or reports you want corrected.

2. Please state as precisely as possible how you would like to see the record worded.

3. If you are aware of anyone else (such as your physician, pharmacist, clinic, etc.) who also may have a copy, from us, of the record you seek to have corrected, please attach a list of those persons or facilities with as much information as you have available regarding names and addresses.

I hereby authorize Premier Physician Network to notify the person or entities included on my attachment so they may have a copy of the record I seek to have corrected and to provide them with the amended information.

Print Name	
Signature*	Date

Note: No amendment request will be processed unless you or your representative have signed this form. If you are the patient's representative, you must provide documentation or an explanation of your authority to act for the patient.