Orlin&Cohen Orthopedic Group

Affiliate of Northwell Health

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

I hereby request that my Protected Health Information be amended as described below:

PATIENT NAME (PRINT): _____ **DATE OF BIRTH:** _____

Street Address: _____

Suite/Apt. Number (if applicable): _____ City: _____

State: _____ Zip Code_____ Phone Number: _____

Facility in which Protected Health Information was created:

_____

_____

Description of requested amendment (attach additional pages, if necessary):

_____

_____

_____

Description of reason for requested amendment:

_____

_____

Description of entities to which the Health System should provide information about this requested amendment if accepted:

_____

_____

Description of entities to which the Health System should provide information about this requested amendment if it is denied:

_____

_____

This form must be submitted to the respective facility's Health Information Management Department and/or Practice Manager.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to Signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

FACILITY USE ONLY:

Received by: _____ Date: _____

☐ Accepted/Date Notice Mailed _____ ☐ Denied/Date Notice Mailed _____

Copy 1 – Patient Medical Record **Copy 2** – Health Information Management **Copy 3** – Patient or Patient's Personal Representative

VD001D (04/04/2022)