CONFIDENTIAL **– This Form Contains Protected Health Information**

Bothwell Regional Health Center

Request for Amendment of Protected Health Information or Record

About this Form

You have the right to request an amendment of your protected health information (PHI) or a record about you maintained by Bothwell Regional Health Center in your medical records called your Designated Record Set for as long as we maintain your PHI.

In general, requests for amendment are made when a person has reason to believe that information in his or her medical record is not accurate.

Your request for amendment must be in writing and you must give us information to explain and support why you are making the request. Please use this form we provide for your convenience. We can help you fill it out and will give you a copy.

The form also explains the PHI amendment process, our obligations and your rights including your rights if we deny your request for amendment in whole or in part.

We will investigate your request promptly and record and respond to your request on this form and give you additional copies of the form as we process and complete action on your request.

Date: _____

Your Name: _____

Birth Date: _____ Last 4 Numbers Social Security # | | | | |

Address: _____
Street Address Apt #

_____
City State ZIP

1. Request for Amendment

A. I request Bothwell Regional Health Center make an amendment to my PHI or a medical record maintained about me. I will identify and describe the PHI or record I believe should be amended as clearly as I can and explain the amendment I am requesting to the best of my ability in the text box below.

Special Instructions

Please describe the information you are requesting be amended as specifically as possible. If information is typed in the text box, the text box will expand as the information is entered. If the information is entered by hand writing and you need more room please use additional sheets of paper.

B. I will explain the reasons I believe my PHI or a record about me should be amended in the text box below.

Special Instructions

Please provide as much supporting information as possible to explain why you believe we should make the amendment you are requesting.

The information I have entered is true to the best of my knowledge.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Title/Authority to Act _____

Receipt by Bothwell Regional Health Center

☐ Identity of the Individual verified

Request for Amendment of Protected Health Information or Record

☐ Identity and Authority to Act of Personal Representative Verified.

Bothwell Regional Health Center

By:

Signature | Printed Name and Title

Date: _____

We will respond to your request within 60 days

Special – Only if Necessary – One Time Extension of Time to Respond to Request

Note: Only if and when we determine that we need more than 60 days to ensure that your request is fully addressed, we will check the box below, explain why we need extension of time – which will not be more than 30 additional days – and notify you of the extension of time by providing a copy.

☐ We need an extension of time to respond to your request for the following reason(s):

We will complete action on your request and respond by the date written below:

_____
Month Day Year

There will be no further extensions of time to respond to the request.

Certification – Written Statement of Extension Provided to Individual

The undersigned certifies this written statement concerning the extension of time to take action on the request, reason(s) for the extension and the date by which action on the request will be completed was provided to the Individual or Personal Representative on:

Date: _____

By means of:

☐ First Class U. S. Mail

☐ Personal Delivery

or by

☐ The Delivery Method described in the text box Below:

Bothwell Regional Health Center
by:

Signature | Printed Name and Title

2. Response to Request for Amendment

(To be completed and provided after thorough review of request)

A. Your request for amendment of your PHI is:

☐ **Agreed to in whole or in part as follows:**

1. We will make the appropriate amendment to the PHI or record that we have agreed to in whole or in part by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.
2. We will provide you with a form on which you may list all persons that you believe should be

notified of the amendment and that you agree we may provide notification that we have made the amendment.

3. We will make reasonable efforts to inform and provide the amendment within a reasonable time to:
   A. Persons identified by the you as having received your PHI and need to be notified of the amendment; and
   B. Persons we know have your PHI that is the subject of the amendment for appropriate and lawful reasons who need to be informed of the amendment so they would not rely on the un-amended PHI in a way that might be detrimental to you.

B. Your request for amendment of your PHI is:

☐ **Denied in whole or in part for a reason marked below:**

1. ☐ The PHI you requested we amend is not available for your inspection under a Federal Health Information Privacy Regulation called Access of individuals to Protected Health Information. For your information and review the Regulation is published the Code of Federal Regulations and numbered 45 CFR § 164.524.
2. ☐ We did not create the PHI you requested we amend. We will reconsider our denial for this reason if you provide us with a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested Amendment
3. ☐ The PHI you have requested we amend is not part of your Designated Record Set.
4. ☐ The PHI you requested we amend is accurate and complete.

Date: _____

Bothwell Regional Health Center
by:

_____

Signature Printed Name and Title

3. If Your Request for Amendment was denied in whole or in part you have the following rights

A. You have the Right to Submit a Written Disagreement

If you disagree with the denial of all or part of the amendment you requested, you may submit a written statement with the reasons for your disagreement to our Privacy Official listed below. We may prepare a written rebuttal, and if we do, we will provide you with a copy.

1. If you make a written statement of disagreement, we will include your request for an amendment or a summary of your request for amendment, our denial, your statement of disagreement and our rebuttal, if any, in your medical records called your Designated Record Set.
2. If you submit a statement of disagreement with our denial of your requested amendment we must include the statement or an accurate summary of the statement in any future lawful disclosure of your protected health information to which the disagreement relates.
3. If you do not make a written statement of disagreement, you may ask us to include your request for amendment and our denial with any future lawful disclosures of the protected health information that is the subject of the amendment by checking the following box and we will do so.

   ☐ I do not choose to make a written statement of disagreement. Include my request for amendment and your denial with any future lawful disclosures of my PHI.

B. You have the Right to make a complaint to us and Federal Authorities

If you disagree with the denial of all or part of the amendment you requested, you may complain to us and you may complain to the Secretary of the U.S. Department of Health and Human Services.

1. We will never penalize or retaliate against you in any manner for filing a complaint or ask you to waive your right to complain.
2. You may complain to us by submitting your complaint in writing to our HIPAA Compliance

Privacy Official. Contact information for our HIPAA Compliance Privacy Official is listed in Section 4 of this form.

3. Information about how to complain to the Secretary, U.S. Department of Health and Human Services is explained in Section 4 of this form.

4. Filing a Complaint

Contact Information for our HIPAA Compliance Privacy Official
Bothwell Regional Health Center Privacy Official
Telephone: 660-827-9591
Office Address
601 E. 14th St.,
Sedalia, MO 65301

How to complain to the Secretary, U. S. Department of Health and Human Services
If you believe our denial of all or part of your request for amendment violated your health information privacy rights or was a violation of the HIPAA Privacy, Security or Breach Notification Rules you may make a complaint to the Secretary of the U.S. Department of Health and Human Services (HHS) through the HHS Office for Civil Rights (OCR). You may submit your complaint in writing or on the Internet using OCR's secure complaint portal. Complete information about making a complaint is on the Internet at http://www.hhs.gov/hipaa/filing-a-complaint/.
You may file a Health Information Privacy Complaint with the Secretary online through the OCR Complaint Portal or use the HHS OCR Health Information Privacy Complaint Form Package to fill out, print and submit by mail, fax or email. You do not have to use the HHS OCR Complaint Form – you may submit a written complaint in your own format by mail or fax to the OCR office in your region or by email to OCRComplaint@hhs.gov.
If you have any questions about filing a complaint you may call the Department of Health and Human Services, Office for Civil Rights toll-free at 1-800-368-1019, TDD: 1-800-537-7697.