FAMILY
Circle of Care

**REQUEST TO AMEND PROTECTED HEALTH INFORMATION**

Patient Name: _____Date of Birth: _____

Address:_____

Phone:_____ Medical Record #_____

**What protected health information do you want changed? Please include reasons to support your request (required)**:

_____

_____

_____

_____

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Please list any persons who need the changed information:

☐ Do not send to anyone
☐ Send to the following (list names, addresses and phone #)

_____
_____
_____

Please note: FCC cannot amend your Protected Health Information (PHI) if :

1. The information is accurate and complete.
2. You do not have the legal right to access the protected health information you want changed.
3. We did not create the information, unless the covered entity that created the information is unavailable to act on your request to change it (If this is the case, please explain above).
4. The information you want changed is not part of your Designated Record Set (medical record, billing record and information used to make decisions about you).

_____

(Signature of Patient or representative) Date

(Please Print Name) Relationship to patient (if other than patient)

**When you have completed this form, please return it to the designated FCC Clinic Front Office**
**We will respond to your request within 30 days of receipt**

Date received at FCC Front Office: _____