Northwestern Medicine®

PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name ____

Patient Address______________________________ City/State/ZIP ______________________________

Date of Birth ________________ Phone ______________________

What document/information needs to be amended? ____

____

____

WHERE WERE YOU TREATED? Please specify date(s) of treatment ______________________________

Hospital:

☐ Central DuPage Hospital
☐ Delnor Hospital
☐ Huntley Hospital
☐ Kishwaukee Hospital
☐ Lake Forest Hospital
☐ Marianjoy Rehabilitation Hospital
☐ McHenry Hospital
☐ Northwestern Memorial Hospital
☐ Palos Hospital
☐ Valley West Hospital
☐ Woodstock Hospital

Physician Group:

☐ Northwestern Medical Group (NMG) ☐ Regional Medical Group (RMG)

Other:

☐ Behavioral Health: Location(s)____

☐ Other ____

Please describe reason for change ____

____

____

____

Time Date Patient Name/Signature for patients age 12 or over

____

Time Date Signature of *(circle one):* Parent Guardian Legal Representative

SEND REQUEST FOR AMENDMENT TO:

Email: nmhprivacy@nm.org
Fax: 312.926.7686

U.S. Mail: Data Integrity/Patient Privacy
676 North Saint Clair Street
18th Floor, Suite 1840
Chicago, Illinois 60611

☐ YOUR REQUEST FOR AN AMENDMENT HAS BEEN **ACCEPTED**.

Your amendment request has been accepted and an amendment will either be made by appending the records or providing a link to the amendment location. We are now in the process of notifying the individuals and/or organizations that you have identified, as well as any person who received the information before it was changed.

☐ YOUR REQUEST FOR AN AMENDMENT HAS BEEN **DENIED**.

DENIAL NOTICE: Your request for an amendment has been denied because:

☐ Health information was not created by this organization.
☐ Health information is not part of the patient's medical record.
☐ Health information is not available to review under federal law.
☐ Health information in the patient's medical record is accurate and complete.

If your amendment request involves mental health information, developmental disabilities or genetic counseling information, your amendment request and our response will become part of your medical record.

Northwestern Medicine®

PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

STATEMENT OF DISAGREEMENT

If you do not agree with our decision to deny the requested amendment, you have the right to submit a Statement of Disagreement explaining the reasons for your disagreement. This statement must be in writing and should be no longer than two (2) typed pages. **Send the completed Statement of Disagreement to:**

Email: nmhprivacy@nm.org

Fax: 312.926.7686

U.S. Mail: Data Integrity/Patient Privacy
676 North Saint Clair Street
18th Floor, Suite 1840
Chicago, Illinois 60611

Your Statement of Disagreement, or an accurate summary of it, **will be included** with the relevant records any time we disclose to others the protected health information. However, we reserve the right to prepare a response to your Statement of Disagreement (called a "Rebuttal Statement"), which we may also include in the relevant records when we make future disclosures of the protected health information. If you wish to exercise this right, please send your Statement of Disagreement to Northwestern Memorial HealthCare Manager of Medical Records/Health Information Management. **If you do not submit a Statement of Disagreement, you may still request that NMHC's clinical affiliates referenced herein include your Amendment Request and this Denial Notice with any future disclosures of your health information.**

☐ Statement of Disagreement submitted **(and will be included with future disclosures)**.

☐ Statement of Disagreement **not** submitted but I wish to have the Amendment Request and Denial Notice included in future disclosures.

☐ Statement of Disagreement **not** submitted and I do **not** wish to have the Amendment Request and Denial Notice included in future disclosures.

Time	Date	Patient Name/Signature for patients age 12 or over
Time	Date	Signature of *(circle one):* Parent Guardian Legal Representative

You may also file a complaint by contacting the NMHC Patient Representative Department at 312.926.3112**. In addition, you may file a complaint with the Secretary of Health and Human Services. Information on how to file a complaint with the Secretary may be found on the website of the Office of Civil Rights at** www.hhs.gov/ocr/hipaa**.**