Northwestern Medicine®

PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient Address: _____ City/State/Zip: _____

Date of Birth: _____ SS# (last 4 digits) _____ Phone:_____

What document / information needs to be amended? _____

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

- ☐ Northwestern Memorial Hospital
- ☐ NM Marianjoy Rehabilitation Hospital
- ☐ NM Lake Forest Hospital
- ☐ NM Lake Forest Hospital – Grayslake
- ☐ NM Central DuPage Hospital
- ☐ NM Delnor Hospital
- ☐ NM Valley West Hospital
- ☐ NM Proton Center
- ☐ Northwestern Medical Group
- ☐ KishHealth System Physician Group
- ☐ Marianjoy Medical Group
- ☐ NM Kishwaukee Hospital
- ☐ NM KishHealth Ben Gordon Center
- ☐ NM KishHealth Cancer Center
- ☐ NM Cancer Center - Warrenville
- ☐ NM Cancer Center - Geneva
- ☐ Regional Medical Group
- ☐ Other _____

Please describe reason for change: _____

_____

_____

SIGNATURE: _____ **DATE:** _____
Patient or Legally Authorized Patient Representative

Relationship to Patient:_____ Day Phone: _____

_____

SEND REQUEST FOR AMENDMENT TO:
Patients' Privacy Rights Coordinator, Health Information Management
Northwestern Memorial HealthCare
Email to nmhprivacy@nm.org
Or fax to 312.926.7686

☐ 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.

Continued on other side

❑ 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.

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 Statement of Disagreement to Health Information Management at:**

Manager, Health Information Management
Northwestern Memorial HealthCare
251 East Huron Street, Lower Concourse L340
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.

SIGNED: _____ **DATE:**_____

Relationship to Patient: _____ Phone: _____

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.

FOR INTERNAL USE ONLY	Date Received:	Date Completed:

❑ Your request for an amendment could not be processed within 60 days. An extension of 30 days to _____

is needed because: _____

Signed: _____ Title: _____ Date: _____

The individual making the request for an amendment has been informed of the decision by copy of this form.	Initial & Date _____
If the request was accepted, an amendment has been made by appending the records or providing a link to the amendment location.	Initial & Date _____
If a Rebuttal Statement was prepared by NMHC, the individual requesting the amendment has been provided a copy of the statement.	Initial & Date _____
If the request was denied, a copy of the Amendment Request, Denial Notice, Statement of Disagreement, if any, and Rebuttal Statement, if any, has been placed in the records.	Initial & Date _____

Signature: _____ Title: _____ Date: _____