Request to amend protected health information (PHI)

Date of request:_____

Patient Name: _____ Date of birth:_____

Mailing address_____ Telephone number: _____

_____

_____

What PHI would you like changed? Please include treatment dates and physician names if you know them.

_____

_____

_____

Why would you like this PHI changed?

_____

_____

_____

Renown Health may deny your request to amend your PHI if:

- Renown did not produce the record
- The record has been reviewed and is considered accurate and complete
- You do not have the right to access the information you want changed
- The information you want changed is not used to make decisions about your care

Signature of patient:_____

OR

Signature of Personal Representative _____

Relationship to patient: _____

(If patient is not a minor child, please include a power of attorney or other documentation demonstrating signer's authority to request this on the patient's behalf)

Please send completed form to:
Renown Health
Health Information Management
850 Harvard Way MS B3
Reno NV 89502

Renown HEALTH Request to amend PHI	Health Information Management 850 Harvard Way MS B3 Reno NV 89502 775-982-2790	Document Type Bar Code	Patient Label