**Request for Amendment of Health Information**

As a patient of St. Mary’s Legacy Clinic (SMLC) you have the right to request amendments to your personal health information that are inaccurate or incomplete. If you want to amend your health information, you must complete this form and return it to SMLC, ATTN: Privacy Officer, 805 S. Northshore Dr., Knoxville, TN 37919. If we deny your request, we will let you know in writing with an explanation of why we are denying it. You have the right to submit a written disagreement to our denial. We will put your statement and requested amendment in to your record. If we continue to disagree with your amendment request, we may put a written rebuttal to your disagreement into your record. If this occurs, we will let you know in writing and send you a copy of our rebuttal.

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| **Patient Information** |
| Name: | Medical Record # or ID #: |
| Birth date: | Contact Phone Number: | Request Date: |
| Current Address: (No., Street, City, State, Zip Code) |
| **Requested Amendment** |
| 1. Date(s) of Entry to be amended/corrected:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Type(s) of Entry to be amended/corrected:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please explain how the entry(s) is incorrect or incomplete:
4. What should the entry(s) say in order to be accurate or complete:
5. Would you like this amendment sent to anyone to whom we may have disclosed information to in the past? □NO □YES

If so, please specify the name and address of the organization or individual: |

**ACKNOWLEDGMENT**

By:

Name (Print) Signature Date

If you are not the patient, please complete, sign, and date below.

By:

Name (Print) Signature Date

□Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_