Taylor Health and Wellness Center
Southwest Missouri State University
901 S. National Avenue, Springfield, MO 65804-0094
Phone: (417) 836-4000 Fax: (417) 836-4133 http://health.smsu.edu

AMENDMENT/CORRECTION REQUEST FORM
FOR PROTECTED HEALTH INFORMATION

Instructions: Sections 1-3 must be completed. Please print all information except for signatures.

Section1: **PATIENT IDENTIFICATION** Print Name:_____
Street Address, City, State & Zip Code:_____
Patient's Social Security Number:_____ Date of Birth:_____

Section 2: **RIGHT TO REQUEST**

I understand I have the right to request amendment to my Personal Health Information (PHI) maintained by Taylor Health and Wellness Center. Pursuant to that right, I hereby request Taylor Health and Wellness Center to make the following amendment:

The information I would like to have amended is the following (attach additional pages as necessary):
_____
_____
I would like this information to be amended in the following manner:_____
_____
_____
I believe the amendment is necessary for the following reason(s):_____
_____
_____

Section 3: **RIGHT OF DENIAL**

I understand Taylor Health and Wellness Center has the right to deny my request for amendment to the extent allowed by law. I also understand that Taylor Health and Wellness Center may deny my request for amendment if it is not in writing or does not include a reason to support the request. In addition, Taylor Health and Wellness Center may deny my request if the information:

1. Was not created by the provider, unless I provide reasonable evidence that the person or entity that created the information is no longer available to act on the requested amendment;
2. Is not part of my clinical or billing records maintained by or for Taylor Health and Wellness Center, or used to make a decision about me;
3. Is not part of the information that I have a right to inspect and copy; or
4. Is already accurate and complete as determined by Taylor Health and Wellness Center.

_____ _____
Signature of Patient Date
(If under 18 years of age-Parent, Legal Guardian, or Legal Representative)

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1:_____

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Section 4: **RESPONSE TO REQUEST** Date Received:_____ Initials:_____
Restriction has been: ☐ GRANTED ☐ DENIED
If denied, check reason for denial:

- ☐ PHI was not created by this organization
- ☐ PHI is accurate and complete
- ☐ PHI is not part of the patient's designed record set
- ☐ PHI is not available to the patient for inspection as required by federal and/or state law

Comments:_____

_____ _____
Signature of Privacy Officer Date

A copy of this form will be filed in the above-named patient's PHI.