PATIENT'S RIGHT TO REQUEST AMENDMENT OF PROTECTED HEALTH INFORMATION

A patient has the right to request an amendment to his or her health record. The Health Information Management (HIM) Department will be responsible for assisting patients and accepting patient requests for amendments.

- Patient requests for amendment of protected health information shall be made in writing to SolutionHealth and should clearly identify the information to be amended, as well as the reasons for the amendment. (form attached)
- Submit the form to the Health Information Management Department. This can be in person or mailed to the following addresses:

- Elliot Hospital
  Health Information Management Department
  One Elliot Way
  Manchester, NH 03103

Southern NH Medical Center
Health Information Management Department
29 Northwest Blvd
Nashua, NH 03061

- Upon receipt of the completed form, an HIM representative will facilitate the provider receiving your request.
- If the provider agrees to the request, the provider will respond with such and make the amendment in your health record. Your request and the response form will be scanned into the record as well. You will be notified of this agreement by letter.
- If the provider does not agree to the request, such will be stated on the physician response form. This form will be made part of your medical record as well as your request and you will be notified of this by letter. You have the right to file a written Statement of Disagreement with Solution Health setting forth why you disagree with this Denial of Request for Amendment, and details of this process are outlined in the notification letter.

REQUEST FOR AMENDMENT/CORRECTION OF PATIENT HEALTH INFORMATION

(Please Print)

Today's Date:_____

Medical Record Number (if known):_____

Patient Name:_____

Date of Birth:_____

Patient Address:_____

_____

Telephone #:_____

After review of my medical record, I do not feel the original documentation accurately reflects my condition/diagnosis/treatment.

Title/Name of the document	Date of the Document	Author of the Document

I request the following amendment/correction be made on my medical record:

_____

_____

_____

_____

I understand the provider may or may not supplement the medical record with an addendum based on my request, and under no circumstances, is able to alter the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

Name/address of the organization or individual (such as your health care provider) you would like this sent to:

_____

_____

_____

_____

Signature (Patient or Legal Representative) Date