BARRINGTON REHABILITATION
REQUEST FOR AMENDMENT OF PHI
(Photocopy / Facsimile may be used as an original)

NAME	***Last***	***First***	***MI***
DATE OF BIRTH		**SOCIAL SECURITY #**	
AKA			

UNDERSTANDINGS:

I understand that **BARRINGTON REHABILITATION** may deny the amendment or correction request for the following reasons:

1. If **BARRINGTON REHABILITATION** did not create the record. However, if **BARRINGTON REHABILITATION** determines that the patient has provided a reasonable basis to believe that the originator of the record is no longer available to act on the request, **BARRINGTON REHABILITATION** must consider the request, but the request may be denied for other reasons as stated in this form.
2. The information which the patient requests to be amended is not part of the **BARRINGTON REHABILITATION** Designated Record Set.
3. The information which the patient requests to be amended is not otherwise available for inspection by the patient under HIPAA regulations governing a patient's right to access his/her PHI, 45 CFR §164.524, such as psychotherapy notes, records that are prohibited by law from being released to the individual, and release of the information may endanger the safety of the individual or another person.
4. If **BARRINGTON REHABILITATION** determines that the information is accurate and complete.

REQUEST: Submit this completed form to the Privacy Officer located at 27401 W. IL Route 22, Barrington, IL 60010, Phone (847) 381-8812, Fax (847) 381-6311

I hereby request an amendment or correction of information maintained in my medical record or other records maintained in the **BARRINGTON REHABILITATION** Designated Record Set that **BARRINGTON REHABILITATION** honor the following restrictions regarding the use and disclosure of the PHI of the individual listed above.

Explain how entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

Identify persons who have received health information about you whom you agree need notice of this amendment, if amendment accepted. Please specify the name and address:

_____

_____

SIGNATURE: **TODAY'S DATE:**

PRINTED NAME: _____

RELATIONSHIP: ❒ Client/Patient ❒ Parent ❒ Guardian ❒ Representative ❒ Conservator ❒ Other _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

FOR OFFICE USE ONLY

Date request received: _____ **Amendment: ❒ Accepted ❒ Denied**

Date of patient notification: _____ **(must be within 60 days of request). If denied, notify in *writing.***

Patient notified by: _____

Reason Denied: ❒ PHI not created by this organization ❒ PHI is accurate and complete ❒ Other: _____

Comments:

_____

_____

Signature of Authorized Personnel: _____ **Date:** _____