



# NORTHERN INYO HOSPITAL

Northern Inyo County Local Hospital District

150 Pioneer Lane · Bishop, California 93514 · Voice (760) 873-5811 · Fax (760) 872-2768  
Medical Records Voice (760) 873-2152 · Billing Office Voice (760) 873-2190 · Fax (760) 873-6734

## REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medical Record No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**We may not act on your request unless this form is completed in full. When completed, please return this form to Northern Inyo Hospital, 150 Pioneer Lane, Bishop, Ca 93514, Attention: Medical Records (for medical record amendments) or Billing Office (for billing amendments).**

Please tell us what protected health information you want to amend or change. Please identify the exact document and provide the wording you would like to place as an amendment to your record.

Please tell us why you want this change (required information).

If we accept your amendment request, we will send the change to any person you tell us below has received a prior copy of your records and needs to have the amended information. Please initial your agreement and supply the following information: Initial here: \_\_\_\_\_

- None
- Send the amendment to the following persons or organizations. You must include names and addresses:

We will also send the amendment to other persons that we know received your records before the amendment if they relied, or might in the future rely, on the information to your harm. Please initial your choice:

- No. Initials: \_\_\_\_\_
- Yes. Initials: \_\_\_\_\_

The hospital is not required to change your records if:

- The information is accurate and complete.
- You do not have the legal right to access the protected health information you want changed.
- The protected health information you want changed is not part of the designated record set, including your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.
- We did not create the record, unless the person who created the information is unavailable to make the change, for example, if the doctor who originally created your records has died. If this exception applies to this request, please explain:

We are required to respond to your request to amend your records within 60 days. Please supply a telephone number where we can contact you if we have questions, and a mailing address so we can notify you in writing of our decision.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

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Signature \_\_\_\_\_ Relationship, if not the patient \_\_\_\_\_ Date \_\_\_\_\_  
**If someone other than the patient signs, the relationship to the patient must be stated**

If you believe your privacy rights have been violated, we encourage you to contact our Privacy Officer at (760) 873-2846 or submit a written complaint. You may place a written complaint with any Northern Inyo Hospital employee, who will forward it to the Privacy Officer.

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**FOR HOSPITAL USE ONLY**

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Received by: \_\_\_\_\_ Date/Time \_\_\_\_\_