# Saint Luke's Health System

## Request for Amendment

Name of Facility Providing Care:________________________________

Patient Name:________________________ Birth Date:____________

Address:________________________________________

Phone Number: (___) _____-_______ Medical Record Number:____________

Amendment is for (Specify Entry):________________________________

______________________________ Date:____________

In the space below, please document and provide rationale for the amendment that you are requesting to have made: (use back side or separate paper if needed)

________________________________________

________________________________________

________________________________________

________________________________________

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s) below:

| Names | Addresses |
| --- | --- |
| | |
| | |
| | |
| | |

Signature:________________________ Date:____________
(Patient or Legal Representative)

**Please Return Form to: Facility Privacy Site Coordinator OR the SLHS Privacy Office at 901 E. 104th St., Mailstop 900N, Kansas City, MO 64131**

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**FOR PRIVACY SITE COORDINATOR USE ONLY**

Request Received By:__________________ Title:__________ Date:__________

Request Assigned To:__________________ Title:__________ Date:__________

- ☐ Accepted
- ☐ Accepted in part with the following changes:____________________
- ☐ Denied (Reason For Denial):
  - ☐ PHI was not created by this organization
  - ☐ PHI is accurate and complete
  - ☐ PHI is not available to the patient for inspection (as required by the federal law)
  - ☐ PHI is not part of the patient's designated record set
  - ☐ Other ____________________________

Signature of Healthcare Provider or PSC:____________________ Date:__________

**PSC to File in Medical Record**