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:

____

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____

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 of Patient or Legal Representative Date

Please Return To: System Privacy Office, 901 E. 104th St., Mailstop 900N, ., Kansas City, MO 64131

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FOR ORGANIZATIONAL USE ONLY

Request Received By: _________________________ Title: ________________Date: _________________

Request Assigned To: _________________________ Title:________________ Date: ________________

☐ Accepted

☐ Accepted 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 Date Signed

Original: File in Medical Record