REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name:

Date of Birth (MM/DD/YYYY):

Street Address:

City:

State:

Zip Code:

Date of Entry to Be Corrected/Amended:

Health Information to Be Corrected/Amended:

Documentation Originally Created By (Provider Name):

Please describe what health information you want to amend or correct. You may attach additional pages if needed.

Please explain why you think the amendment or correction that you are requesting is appropriate or necessary. Note that your request may be denied if you do not provide a reason to support your request. You may attach additional pages if needed.

If we decide to amend or correct the health information as you requested, the amendment/correction will be sent to the person(s) or organization(s) you identify below. You may attach additional pages if needed.

1. Person or Organization:

Phone Number (include area code):

Street Address:

2. Person or Organization:

Phone Number:

Street Address:

My Rights

I understand that my request may be denied if:

1. The original information was not created by Rezilient Health;
2. The original information is, in our professional judgment, accurate and complete;
3. The original information is not part of the designated record set; or
4. The original information is not available to me for inspection under applicable law

A written determination (acceptance or denial) will be provided within the legal time frame of your residential state, or we will tell you that we need more time (up to 30 additional days) to decide.

If Rezilient Health denies your request for amendment or correction, we will let you know in writing how to submit a Statement of Disagreement, a complaint, or how to request that we include your amendment request in your protected health information that we maintain.

I have read and understand the information in this Amendment Request Form.

Patient Signature:	
Printed Name:	Date:
Signature of Authorized Representative:	
Printed Name:	Date:
Relationship to the patient/authority to act for the patient:	
Witness or Interpreter:	

Please return this completed form to Rezilient Health via one of the following methods:

1. Mail to: ATTN: Amendment Request, Rezilient Health, 5595 Pershing Ave, St Louis, MO 63112

2. Email to: medicalrecords@rezilienthealth.com

FOR INTERNAL USE ONLY

Date Received:	Date Processed:
Received by Name: Title:	