Patient Label

Trinity Health
Of New England

REQUEST FOR CORRECTION / AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

_____

To Who It May Concern: I, _____ , am requesting an amendment of my protected health information maintained by Saint Francis Hospital and Medical Center ("SFHMC") for date of service:

_____

I request that the following correction/amendment(s) be made to my protected health information

_____

_____

_____

_____

_____

_____

The reason(s) for the requested amendment(s):

_____

_____

_____

_____

_____

Please identify individuals or organizations that have received protected health information about you in the past that should be notified about the requested amendment to your protected health information.

_____

_____

_____

I understand that my rights with regard to this request for amendment are set forth in SFHMC's Notice of Privacy Practices.

By signing below, I agree that SFHMC has permission to notify the persons or organizations listed above or others deemed necessary by SFHMC of any amendment accepted by SFHMC and related information.

_____ ____/____/____ _____

Signature (Patient/Authorized Representative) Date Time

As per your request, we are providing you with an opportunity to request a correction/amendment of your health information. Please complete the areas above that apply to your request and return to the attention of:

Privacy Official
Saint Francis Hospital & Medical Center
114 Woodland Street
Hartford, CT 06105