ST. MARY'S
HEALTH CARE SYSTEM
A Member of Trinity Health

REQUEST TO AMEND OR CORRECT HEALTH INFORMATION HELD BY St. Mary's Health Care System, Inc.

Name of requesting individual: _____ Date: _____
(Last) (First) (M.I.) MM/DD/YYYY

Patient registration or medical record #: _____

Address: _____

Phone Number: _____ Social Security #: _____ Date of birth: _____
(Optional) MM/DD/YYYY

Describe the amendment or correction that you wish us to make:

_____

_____

Describe why you think the amendment or correction that you are requesting is appropriate or necessary:

_____

_____

Identify any other persons or entities you believe have received your health information and need to be notified of the amendment/correction that you are requesting.

_____

_____

Information about Your Amendment/Correction Rights

We will not process your request for an amendment/correction of your health information if it is not made in writing on this Form or does not tell us why you think the amendment is appropriate.

We will act on your request within 60 days (or 90 days if the extra time is needed) and will inform you in writing as to whether the amendment will be made or denied.

We may deny your request if you ask us to amend information that:

- Was not created by Trinity Health, unless the person who created the information is no longer available to make the amendment;
- Is not part of the information Trinity Health keeps about you;
- Is not part of the information that you would be allowed to see or copy; or
- Is determined by us to be accurate and complete.

If we deny your requested amendment, we will tell you in writing how to submit a statement of disagreement or a complaint, or to request that we include your amendment request in your health information that we maintain.

By submitting this form, I hereby request Trinity Health to amend or correct my health information, as described above, that Trinity Health maintains.

I understand that if Trinity Health agrees to my request, they will provide the amendment/correction to relevant third parties, including, but not limited to, the individuals I identified in #5 above, and third parties with which Trinity Health contracts to provide services to or on behalf Trinity Health.

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Signature of Patient or Personal Representative

Date

Name of Workforce Member who received this form

Date form received

Internal Use Only

- ❑ We have reviewed your request for Trinity Health to amend your health information and have determined that Trinity Health will grant your request.
- ❑ Trinity Health has reviewed your request to amend your health information and has determined that it must deny your request. Reason for denial: