



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:

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

.....
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

Please Return To: Privacy Office, 4401 Wornall, Kansas City, MO 64111

Original: File in Medical Record