INFIRMARY HEALTH SYSTEM, INC. "Covered Entities"

FORM: **Request for Amendment to PHI**	1) Page ___ of ___

2) Name of Facility / Hospital: ______________________________________ 3) Hospital No.: _____________________

4) Name of Individual: ____ 5) Birth Date: ___/___/___
(Please Print)
6) Address: ____ 7) Phone No.:_________________

8) Person submitting Request:
(if different from the Individual / Patient): ______________________________ 9) Relation to Patient: ______________________
(Please Print)

10) Details of Request (Use Additional Sheet if Necessary):
____
____
____

11) Please list any organization or individual, along with their address, who may have received this information in the past. Should your request for amendment be approved, a copy will be forwarded to them. (Use additional Sheet if Necessary):

Name: ____ Address : ____
____ ____

Infirmary Health System (IHS) and/or the health care provider that documented the information being requested for amendment may deny your request if:

- The information was not created by IHS;
- It is not part of a IHS designated record set, such as the medical record;
- It is not part of the information which you would be permitted to inspect and copy/ or;
- IHS and/or the health care provider determine the information is accurate and complete.

IHS will respond to your response within 60 days of receiving the request. If IHS is unable to act on the request for amendment within 60 days, the organization with notify you in writing prior to the end of the 60 day deadline extending the process for another 30 days. For more information on the Amendment Request process, you can contact the Corporate Compliance Office at 251-435-5823.

Please mail the completed form to:
Infirmary Health
Attn: Health Information Management
5. Mobile Infirmary Circle
Mobile, AL 36607

____

12) Signature: ____ 13) Date Completed : ___/___/___

OFFICE USE ONLY:
Nature of Disposition:____
Further Action indicated by requestor: YES_____ NO________ If yes, indicate:____
Date of Disposition:____