REQUEST FOR AMENDMENT OF MEDICAL OR BILLING RECORD

To submit a request for amendment, please complete, sign and return the attached form to:

Privacy Officer
190 E Bannock Street - Compliance Dept.
Boise, ID 83712
Fax: 208-493-0572
Email: privacyofficer@slhs.org

The attached form may be used to request an amendment to a record of your medical care. We are required to amend your medical record after receiving a signed amendment request unless

(1) We did not create the information,*
(2) We do not maintain the information as part of your record,
(3) We determine that the information is accurate and complete as currently recorded,
(4) The information is the type that would not be available to you for inspection.

Please be aware that will we not delete or alter the original documentation in the medical record if the information is determined to be complete and accurate.

* If we did not create the information that you want to have amended, you may submit reasonable evidence that the person or organization that originally created the information at issue is no longer available (e.g., evidence that the doctor who created the information has died, etc.), and we will consider your request.

HIPAA, the Health Information Portability and Accountability Act, requires that we respond to amendment requests within 60 days of receiving them whenever possible. HIPAA does allow one 30-day extension; we are required to notify you if we do need the 30-day extension. If we deny your request to amend, you may submit a statement of rebuttal, which will be included in all subsequent disclosures of the information at issue. If you choose not to submit a statement of rebuttal, you may request that your amendment form be included in all subsequent disclosures of the non-amended health information.

For more information about amending a medical record, you may contact the Privacy Officer at 208-493-0383. Note, however, that requests for amendment must be made in writing and will not be accepted over the phone.

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Today's Date: ____________________

Patient's Name: ____________________

Medical Record Number (if known): ____________________

Birth Date: ____________ Social Security: ____________________

Address: ____________________

Phone (Home): ____________ (Work): ____________________

Describe the information that you would like to be amended (e.g., physician notes, lab test results)

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On what date(s) was the care that is described in the record provided? ____________

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What is incorrect about the record? What would you like to change/add to the record?

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To your knowledge, has anyone received or relied on this information (e.g., your doctor, another health care provider, an insurance company)? If yes, please provide the name(s) and address(es) of those individuals or organizations so that we may inform them of any amendments.

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Signature: ____________________ Date: ____________

Personal Representative Information: If you are not the patient, please fill in the following: Note: Documentation of your identity and that you can legally act on behalf of the patient are required.

Your Name: ____________________

Relationship to the Patient: ____________________

Address (if different than above): ____________________

Phone (if different than above) (Home)____________ (Work) ____________

Signature: ____________________ Date: ____________