GO EAST MEDICAL SERVICES
行 健 醫 療 中 心

GEMS#:

NAME:

Date of Birth:

REQUEST FOR A RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Date of Request: _____/_____/_____

Name: _____ **Phone Number:** _____

Address: _____ **Email Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Date(s) of Information to be Amended: _____

_____

Type:
☐ Progress Note
☐ Health Inventory
☐ Other: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Why? *(Add attachment if additional space is needed)*

_____

_____

_____

_____

We may deny your request for an amendment if the information in our Medical Record was:

1) Accurate and complete;
2) Not created by us, unless the person or entity that created the information is no longer available to make the amendment;
3) Not part of the medical information kept by or for GEMS;
4) Not part of the information which you would be permitted to inspect and copy (e.g. psychotherapy notes).

When amendment is accepted, your provider will supplement your Medical Record with an addendum since no one is allowed to alter the original documentation in a record.

We will respond to your request within 60 days. If this request is denied, you have the right to submit a written disagreement.

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past?

☐ Yes - If yes, please specify the name and address of the organization or individual. A copy of this form will now accompany each subsequent request for information regarding the dates covered in this entry.

☐ No

1. Name: _____ Address: _____
2. Name: _____ Address: _____

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3. Name: _____ Address: _____
4. Name: _____ Address: _____
5. Name: _____ Address: _____

_____ _____
Signature of Patient or Legal Representative | Date

_____ _____
Name of Legal Representative | Relationship of Legal Representative

_____ _____
Signature of Witness (Required if patient is unable to sign) | Date

Office Use Only:

Print Provider Name _____ Amendment/Correct ☐ Approve ☐ Deny Denial Reason ☐ 1 ☐ 2 ☐ 3 ☐ 4 Date _____

Date | Received by HIS Department _____ | Routed to Provider _____ | Received Response from Provider _____ | Patient Notified _____

Comments from Healthcare Provider:

_____

_____

_____

Provider Signature: _____ Date: _____

Patient's Response to Provider's Statement: ☐ Agreement ☐ Disagreement