Southwest Medical™
Part of OptumCare™

# REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____ MRN: _____ DOB: _____

Patient Address: _____

_____
City State Zip Telephone Number

Date of Entry to be amended: _____ Type of Entry to be amended: _____

Please explain how the entry is incorrect or incomplete. _____

_____

_____

_____

☐ If approved, please check this box if you would like this amendment sent to anyone to whom we may have disclosed this information to in the past.

_____ _____
**PRINT NAME** and **SIGNATURE** of Patient or Legal Representative Date

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## For Southwest Medical Associates Staff Use Only

Date Received _____

☐ Accepted ☐ Denied REASON FOR DENIAL

☐ PHI was not created by this organization ☐ the originator is no longer with this organization

☐ PHI is accurate and complete ☐ PHI is not part of patient's designated record set

Provider's Comments: _____

_____

_____

_____

_____ _____
Signature – **Provider** Date

_____ _____
Signature – **Health Information Management** Date