AtlantiCare

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION FORM

Complete and mail this form to: Privacy Officer, AtlantiCare Health Park, 2500 English Creek Ave., Bldg. 500
Egg Harbor Twp., NJ 08234 (609) 407-2251

Patient Information: (Please print)

_____

Last First MI Date of Birth

_____

Address Telephone

□ AtlantiCare Regional Medical Center	□ AtlantiCare Behavioral Health	□ AtlantiCare Health Services
□ AtlantiCare Surgery Center	□ AtlantiCare Physicians Group	□ Other _____

I hereby request that the AtlantiCare entity indicated above amend [please check all boxes that apply]:

□ My medical records

□ My billing records

□ My enrollment, payment, claims adjudication, case or medical management records

□ My records used by or for AtlantiCare to make decisions about me as more specifically described below

I understand that AtlantiCare may deny this request as permitted under federal law. I further understand that if AtlantiCare denies my request, I will be informed in writing by AtlantiCare of its reason for the denial and what I should do if I disagree with the denial. I further understand that AtlantiCare will notify me of its decision to accept or deny my request within 60 days of receiving this request. If AtlantiCare is unable to comply with my request within this period, I understand that it may extend the applicable deadline for up to an additional 30 days by notifying me in writing.

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results)

_____

_____

_____

_____

2. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services)

_____

3. What is your reason for making this request? _____

4. How is the entry incorrect, incomplete, or outdated? _____

_____

_____

5. What should the entry say to be more accurate or complete? (Please be as specific as possible):

_____

_____

_____

_____

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? ___ Yes ___ No

If yes, please specify the name and address of the organization(s) or individuals(s).

_____

_____

_____

_____

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Personal Representative / Relationship to Patient Date

Amendment Request Received By:

_____

Name Title Date