



REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information and the process we follow once we have received your request. To request an amendment to your records, complete and return the following request form.

PATIENT INFORMATION

Patient Name: _____
Last First MI

Date of Birth: _____

Address: _____

Telephone: _____

(daytime)
(evening)

Email Address (optional): _____

AMENDMENT REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

What information would you like to amend?

How do you believe the information should be amended?

Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request.



MR2C747



Stony Brook
Medicine

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If this request is granted is there an individual, other person or organization who you believe may have the un-amended information and may need the amended information? If you would like us to forward the amended information to this individual, some other person or organization please provide the contact information below:

Name _____
(individual/business/organization)

Name _____
(individual/business/organization)

Mailing _____
(street including building/suite number)

Mailing _____
(street including building/suite number)

Address _____
(City, State, Zip)

Address _____
(City, State, Zip)

Business Phone (____) _____
(area code)

Business Phone (____) _____
(area code)

You may attach a separate page if more space is needed.

REQUESTOR UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Stony Brook University Medical Center amend the health information as I have explained above.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

Stony Brook University Hospital
Health Information Management Department
500 Commack Road - Commack, NY 11725

Stony Brook Eastern Long Island Hospital
Health Information Management Department
201 Manor Place - Greenport, NY 11944

Stony Brook Southampton Hospital
Health Information Management Department
240 Meeting House Lane - Southampton, NY 11968

For [Medical Center] Use Only: MR# ENC#

Date Received: (MO/DY/YR) ___/___/___

Disposition of Request: ___ GRANTED ___ DENIED ___ PARTIALLY DENIED

Patient Notified In Writing On This Date: (MO/DY/YR) ___/___/___

Name of HIM Staff Member Processing This Request: _____