ALASKA TRIBAL HEALTH SYSTEM

REQUEST FOR AMENDMENT TO PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:	Patient Record Number:
Patient Address:	City, State, Zip:	Telephone # Alternate #
Tribal Health Organization Responsible:	Date of Entry to Be Corrected/Amended:	Date of Entry to be Amended:
Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?		
Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.		
Name:	Address:	
Name:	Address:	
Name:	Address:	
Signature of Patient or Legal / Personal Representative:		Date:

Disclaimer: All fields on this request **must be completed** for it to be valid. Please complete one amendment request form per note that needs an amendment. Submit the completed form(s) to the Tribal Health Organization that generated and maintains the note (Ex. ANMC note send to ANMC HIM; BBHC note send to BBHC HIM; KANA note send to KANA HIM).

For Organization Use Only:

Date Received in HIM:	HIM: Name and Title of Staff member processing request:
Amendment has been ☐ Accepted ☐ Denied	Signature of Healthcare Practitioner (if denied) / Date:
Healthcare Practitioners Reason for Denial:	