ADMINISTRATIVE RECORDS - S
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BAPTIST HEALTH®

Request for Amendment of Health Information

Patient Info

Patient Full Name:	Previous Last Name:	Date of Birth:
Street Address / City / State / ZIP:		Last 4 digits of SSN#:
Email Address:	Telephone #:	

Information regarding the amendment

☐ Baptist Heath Corbin ☐ Baptist Health Floyd ☐ Baptist Health Hardin

☐ Baptist Health LaGrange ☐ Baptist Health Lexington ☐ Baptist Health Louisville

☐ Baptist Health Deaconess Madisonville ☐ Baptist Health Paducah ☐ Baptist Health Richmond

☐ Baptist Health Medical Group (List Provider or Practice Name) / Other :

Please include the date, who published the note and how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

Sign

_____ **Signature of Patient or Legal Representative**

_____ **Relationship to Patient**

_____ **Date**

FOR BAPTIST HEALTH USE ONLY

Date received: _____

Name of Caregiver(s) reviewing the request:

Amendment request status:

☐ Approved
☐ Denied

If Denied, check reason for denial:

☐ Baptist Health did not create PHI for this entry
☐ PHI is not available to the patient for inspection as required by federal law
☐ PHI is not part of the patient's designated record set.
☐ PHI is accurate and complete.

Comments from caregiver(s):
If there is a correction in the medical record, please state what is being changed or corrected.

Sign

_____ **Approver Print Name**

_____ **Approver Signature**

_____ **Date**