Bronx Treatment Center

REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

Patient Name	**Date of Birth**	**Account No.**
Patient Address		
State	**Zip Code**	
Date of Entry to be Corrected/Amended	**Information to be Corrected/Amended**	
Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Use additional sheets if needed and attach to this form.		
Please indicate whether there is anyone to whom you would like us to notify of the amendment to your protected health information. ☐ **Yes** ☐ **No**		
If yes, please provide the name, address and telephone number of the organization(s) or individual(s):		
Signature of Patient or Personal Representative		**Date**
If Personal Representative, state relationship to patient		

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Date Received	**Amendment has been** ☐ **Accepted**	☐ **Denied**
If denied, check reason for denial ☐ **PHI is not part of the patient's designated record set** ☐ **Record is not available to the patient for inspection under Federal law** ☐ **Essen did not create record** ☐ **Record is accurate and complete**		
Comment of Healthcare Provider		
Signature of Healthcare Provider *(if applicable)*	**Title**	**Date**