



Office use only, MR#: \_\_\_\_\_  
Date received: \_\_\_\_\_

**Patient/Patient Representative Request to Amend Protected Health Information (PHI)**

Mercy Health facility name (Hospital, Clinic, Physician office, etc. - treated at (be specific) :

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient phone #: \_\_\_\_\_

Patient mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

- 1. Please identify/describe the documents/reports you want amended (e.g. physician report or note), be specific and include date(s) of report/note you identified:

\_\_\_\_\_  
\_\_\_\_\_

- 2. What is the reason for the request? How is the current document/report inaccurate or incomplete:

\_\_\_\_\_  
\_\_\_\_\_

- 3. What should the document/report say or include to be accurate and complete:

\_\_\_\_\_  
\_\_\_\_\_

- 4. Do you know of anyone who may have received or relied on the document/report in question (such as your doctor, pharmacist, health plan or other healthcare provider)?  
If yes, please provide name and address of the organization or individual to whom the amended document/report should be sent to if amendment is approved.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date of signature

If signed by Legal Representative, please print name: \_\_\_\_\_

Indicate relationship to the patient, (Attach a copy of paper work verifying legal authority):

\_\_\_\_\_

Submit completed requests to: Keianna Spencer, Privacy Analyst, [Keianna\\_Spencer@bshsi.org](mailto:Keianna_Spencer@bshsi.org)  
1701 Mercy Health Place Cincinnati, OH 45237

Request will be responded to within 60 days of receipt