Date: _____

Patient name: _____

Date of birth: _____ Medical Record #: _____

Please tell us what protected health information you want changed:

_____

_____

_____

_____

Please tell us why you want this change. You must give a reason:

_____

_____

_____

_____

NOTE: We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide.

Tell us where to send you a letter:

_____

_____

Give a phone number so we can call you: _____

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Tell us if there are any such persons who need the changed information:

☐ No Initials: _____ ☐ Yes Initials: _____

Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

(over)

Natividad MEDICAL CENTER
1441 CONSTITUTION BLVD. • SALINAS, CA 93912-1661 • (831) 755-4111

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Label

REQUAMEPROHEA

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

☐ No Initials: _____ ☐ Yes Initials: _____

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   _____

   _____

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

Date: _____ Time: _____ ○ AM / ○ PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.natividad.com or at Natividad Medical Center or by sending a written request to Natividad Medical Center, Health Information Management, 1441 Constitution Boulevard, Salinas, CA 93912.

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact the Privacy Officer at 831-783-2559. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

When you have finished filling out this form, please send it to Natividad Medical Center, Health Information Management, 1441 Constitution Boulevard, Salinas, CA 93912.