Request for Amendment of Protected Health Information

This request applies to the protected health information created at:

☐ Herrin Hospital ☐ Memorial Hospital of Carbondale ☐ St. Joseph Memorial Hospital

☐ Southern Illinois Healthcare Medical Group

Patient Name First: ________________ Middle: ____________ Last: ___________________

Home Address: Street: ____

City: ______________________________ State: __________ Zip: _________

Phone Number: ____________________________

Date of Birth: ____________________________

I hearby request that Southern Illinois Healthcare / Southern Illinois Healthcare Medical Group amend my (please check all boxes that apply:

☐ Medical records ☐ Billing Records

☐ Records used by Southern Illinois Healthcare / Southern Illinois Healthcare Medical Group to make decisions about me

☐ Enrollment, payment, claims adjudication, case or medical management records

I understand that Southern Illinois Healthcare/ Southern Illinois Healthcare Medical Group may deny this request as permitted under federal or Illinois law, and that I will be informed by Southern Illinois Healthcare concerning the basis for the denial along with instructions concerning my right to submit a statement of disagreement with such denial. I further understand that Southern Illinois Healthcare /Southern Illinois Healthcare Medical Group will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If Southern Illinois Healthcare /Southern Illinois Healthcare Medical Group is unable to comply with my request within this time frame I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.

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1. Describe the information you would like to have amended (.e.g., nursing/physician notes, tests results).

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2. Identify the date(s) of the entry to be amended (e.g., date of visit, treatment or other healthcare services.)

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3. What is your reason for making this request?

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4. How is the entry incomplete, incorrect, or outdated?

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5. What should the entry say to be more accurate or complete? (Please be as specific as possible.)

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6. Do you know of anyone who may have received or relied on the information in question (e.g., your doctor, pharmacist, health plan or other healthcare provider)?
   ________ YES ______ NO
   a. If YES, please specify the name(s) and address(s) of the organization(s) or individual(s)

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Signature of patient or personal representative: ______________________________

Date: ______________________

Return this form to:
Privacy Office
Health Information Department
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62901