



# Pediatric Partners of Virginia HIPAA Form C

## Request for Correction/Amendment of Protected Health Information

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

**Patient Street Address:** \_\_\_\_\_ **Account /Chart:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Type of Entry to be Amended:**  Visit Note  Nurse Note  Hospital Note  Prescription Information  Patient History

**Please explain how the entry is inaccurate or incomplete:** \_\_\_\_\_

**Please specify what the entry should say to be more accurate or complete:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian
Printed Name
Date

**FOR INTERNAL PURPOSE ONLY:**

Date Request Received: \_\_\_\_\_ Date Compliance Officer Received this Request: \_\_\_\_\_

Compliance Office Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Amendment has been:**  Accepted  Denied  Denied in part/Accepted in part (A reason must be checked if request for correction/amendment is denied in whole or in part)

**Reason for Denial:**

- PHI was not created by this organization
- PHI is not part of the patient’s designated record set.
- PHI is not available to the patient for inspection in
- PHI is accurate and complete

**Comments from healthcare provider who provided service:** \_\_\_\_\_

**Name of Staff Member Completing Form:** \_\_\_\_\_ **Title:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Healthcare Provider Who Provided Service Date**

\* If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, Attn: Corporate Administrator, Pediatric Partners of Virginia 3458 Lauderdale Drive, Henrico VA 23233. If you do not provide us with a statement of disagreement, you may request that we provide your original request for amendment and our denial with any future disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Corporate Administrator at the above stated address or the Secretary of the U.S. Department of Health & Human Services.

**\*Practice must inform patient that a written request is required, and that the patient is required to provide a reason to support the requested change.**