Exact Care Pharmacy

REQUEST FOR AMENDMENT to PHI

Name of Individual: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

I am requesting that the healthcare provider amend my Protected Health Information (PHI) or records as follows: *(please be specific and attach additional sheet if necessary)*

The reason for the requested amendment is as follows:

I authorize the healthcare facility to notify the following persons known to me as having received the disputed information: (*attach additional sheet if necessary)*

I understand that the healthcare facility will contact those persons identified by me (above) and any other persons that the healthcare facility is aware of possessing the information that is the subject of the amendment if the request for amendment is accepted by the healthcare facility. The healthcare facility will send notification of the request approval or denial to me within sixty (60) days from the healthcare facility's receipt of this request unless the healthcare facility requests an extension.

Date: _____ Signature of Individual/Legal Representative: _____

Legal Representative's Authority: (Relationship to Individual) _____

You may file the completed request with the Healthcare Facility or Mail to:

Exact Care Pharmacy
Todd Donnelly, RPh
8333 Rockside Rd
Valley View, OH 44125-6126

***Office Use Only* – Please Do Not Write Below This Space**

❒ **Acceptance Granted** ❒ **Acceptance Denied** ❒ **Notice Mailed to Individual**

Date Rec'd: _____ **Initials:** _____