Raymond W. Bliss Army Health Center

Patient Request for Amendment of Protected Health Information

The purpose of this form is to allow a patient the means to request an amendment of their medical information in accordance with DODM 6025.18

The proponent of this form is the Patient Administration Division

Section I – Patient Data

1. Name (Last, First, MI):	2. Date of Birth (DD MMM YY):	3. Patient DoD ID #:
4. Home Phone:	5. Work Phone:	6. Cell Phone:

7. Mailing Address:	8. City:	9. State:	10. Zip Code:

11. Email Address:

Section II – Medical Record Information Requested for Amendment

12. Health Clinic & Provider Name:	13. Type of Treatment (Outpatient, BH, FAP, etc.):	14. Location in AHLTA (Encounter S/O, A/P, Problem List, Consult, etc.)

15. Date(s) of treatment or time frame (DD MMM YY):

16. Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

17. Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual?

Name	Address
Name	Address

I understand my request for amendment may be disapproved.

18. Signature of Patient or Legal Guardian (Print name if different than block #1 above or CAC sign)	19. Relationship to patient (Self, Father, Mother, Legal Guardian, etc.):	20. Date (DD MMM YY):

Mail completed form to: **Raymond W. Bliss Army Health Center**
ATTN: Patient Administration Division, HIPAA Privacy Officer
2240 E. Winrow Road
Fort Huachuca, AZ 85613-7079

Raymond W. Bliss Army Health Center

Patient Request for Amendment of Protected Health Information

Patient Name (Last, First, MI):	Date of Birth (DD MMM YY):	Patient DoD ID #:

FOR RAYMOND W. BLISS ARMY HEALTH CENTER USE ONLY

Section III – Patient Administration Division (PAD)

1. Date Request Received:	2. Date Forwarded to Healthcare Provider:

3. Remarks:

Section IV – Healthcare Provider

4. Request for Amendment Has Been (reference Sec II, #12-16): ☐ Accepted ☐ Denied

5. Date Accepted/Denied:

6. If denied, check reason for denial:

☐ PHI is not available to the patient for inspection as required by federal law (e.g., Psychotherapy Notes)

☐ PHI is accurate and complete ☐ PHI was not created by RWBAHC

7. Comments from Healthcare Provider:

8. Rank/Name and Title of Healthcare Provider:	9. Signature of Healthcare Provider:

Route this form to the Patient Administration Division after the HCP has completed Section IV

Section V – Patient/Guardian Notification (PAD)

10. Date Patient Notified:

11. Rank/Name of Individual Making Notification:	12. Signature: