Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

With certain exceptions, you have a right to request that Thomas Jefferson University (TJU) and its clinical operations, including Jefferson Health Northeast, and Aria Health Physician Services, (collectively "Jefferson") amend your health information in your Jefferson health care records ("Designated Record Set"). Jefferson may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by Jefferson (unless the person or entity that created the information is no longer available); is not part of the Designated Record Set; or would not be available for inspection (e.g., Psychotherapy Notes or information compiled for civil, criminal or administrative proceedings), or other as permitted under federal law.

You further understand that if Jefferson denies your request, you will be informed in writing by Jefferson of its reason for the denial and what you should do if you disagree with the denial.

I. PATIENT IDENTIFICATION SECTION

Patient Name: _____

Date of Birth _____ Date(s) of Treatment: _____

Address: _____

_____

Telephone No.: _____ Email Address: _____

II. REQUEST

I hereby request that Jefferson amend my records specifically described below:

1. Describe the information to be amended (e.g. procedures, nursing/physician notes, test results. _____

   _____
2. Date(s) of information to be amended (e.g. date of office visit, treatment, or other health care services). _____

   _____
3. What is the reason form making this request? _____

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 How is the entry incorrect, incomplete, or outdated?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

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

   _____

Do your know anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other care provider)? ☐ Yes ☐ No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s) _____

_____

I understand that if Jefferson approves my request to amend my record, Jefferson will not delete the original information in the Designated Record Set, but instead may choose to identify the information in the Designated Record Set that is the subject of my Request for Amendment and provide a link to the location of the amendment.

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____

Printed Name of Legal Representative (*if applicable*) Relationship to Patient

Jefferson Northeast

Instructions for Mailing the Request for Amendment of Protected Health Information Form

1. Please complete all sections of the Request for Amendment of Protected Health Information Form.

2. Please mail the completed form to:

Jefferson Torresdale Hospital
C/O Thomas Jefferson University Hospitals, Inc.
Health Information Management Department
111 South 11th Street,
Gibbon Building, Suite 1950
Philadelphia, PA 19107

Phone: 215.955.6627
Email: HIM@jefferson.edu

Hours of Operation:
Monday – Friday 8:30 a.m. – 5:00 p.m., excluding holidays.