Navicent Health Form

A0200 HEALTH INFORMATION AMENDMENT REQUEST FORM

To request a correction or change (amendment) to your health information, please complete the information below and submit this form to: Navicent Health HIM, 777 Hemlock St. MSC#148, Macon, GA 31201. You will receive a response to your request within 60 days of the day we receive your written request.

Patient Name: ____ Date of Birth: ____

Address: ____City: _________________________State: ____ Zip Code: ________

Home Phone: (____) ______________________________________ Cell Phone: (____) _____________________________________

Please name the Navicent Health Facility/Practice and location you want to change your record:

____

Include the name(s) of the Person/Caregiver/Provider who wrote the information you are asking us to change:

____

Include the treatment dates of the information and documents you want changed: _______________________________________

Describe the information you want changed:

____

____

What should the record say to be more correct or complete?

____

____

____

List the name(s) of the people/organizations you would like us to notify of any changes made to your medical record:

Name	Address
____	____
____	____

Signature of Patient or Representative: ____ Date: _________Time:__________

If signing as authorized representative, describe your authority to act for the patient, for example, parent, Healthcare Power of Attorney and submit documentation showing such authority, as appropriate: ____

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Amendment has been: ____Accepted ____Denied ____Partially Accepted/Denied

If denied (fully or partially), check reason: ___ PHI is was not created by Navicent Health ___ PHI is accurate and complete

___ PHI is not part of the patient's designated record set ___ PHI is not available for amendment as permitted by federal law

Signature: _______________________________ Print Name: ____________________________________ Date:_______ Time:______

Comments: ____