MERCYHEALTH

Office use only, MR#: _____
Date received: _____

Patient/Patient Representative Request to Amend Protected Health Information (PHI)

Mercy Health facility name (Hospital, Clinic, Physician office, etc. - treated at (be specific):

_____

Patient Name: _____ Date of Birth: _____

Patient phone #: _____

Patient mailing address: _____

City: _____ State: _____ Zip code: _____

1. Please identify/describe the documents/reports you want amended (e.g. physician report or note), be specific and include date(s) of report/note you identified:

   _____

   _____

2. What is the reason for the request? How is the current document/report inaccurate or incomplete?

   _____

   _____

3. What should the document/report say or include to be accurate and complete:

   _____

   _____

4. Do you know of anyone who may have received or relied on the document/report in question (such as your doctor, pharmacist, health plan or other healthcare provider)?
   If yes, please provide name and address of the organization or individual to whom the amended document/report should be sent to if amendment is approved.

Name: _____

Address: _____

_____ _____
Signature of Patient or Legal Representative Date of signature
If signed by Legal Representative, please print name: _____
Indicate relationship to the patient, (Attach a copy of paper work verifying legal authority):
_____

Submit completed requests to: Privacy Department – Amendment Requests
1701 Mercy Health Place Cincinnati, OH 45237 or email: amendment-requests@mercy.com

Request will be responded to within 60 days of receipt. Revised: 06/27/2023