



INFIRMARY HEALTH SYSTEM, INC. "Covered Entities"

FORM: Request for Amendment to PHI	1. Page ___ of ___
2. Name of Facility / Hospital: _____ 3. Hospital No.: _____	
4. Name of Individual: _____ 5. Birth Date: ___/___/___ (Please Print)	
6. Address: _____ 7. Phone No.: _____	
8. Person submitting Request (if different from the Individual / Patient): _____	
9. Relation to Patient: _____ (Please Print)	
10. Details of Request (Use Additional Sheet if Necessary): _____ _____ _____	
11. Please list any organization or individual, along with their address, who may have received this information in the past. Should your request for amendment be approved, a copy will be forwarded to them. (Use additional Sheet if Necessary): Name: _____ Address: _____ _____ _____	
Infirmary Health System (IHS) and/or the health care provider that documented the information being requested for amendment may deny your request if:	
<ul style="list-style-type: none"> • The information was not created by IHS; • It is not part of a IHS designated record set, such as the medical record; • It is not part of the information which you would be permitted to inspect and copy/ or; • IHS and/or the health care provider determine the information is accurate and complete. 	
IHS will respond to your response within 60 days of receiving the request. If IHS is unable to act on the request for amendment within 60 days, the organization with notify you in writing prior to the end of the 60-day deadline extending the process for another 30 days. For more information on the Amendment Request process, you can contact the Corporate Compliance Office at 251-435-5823.	
Please send the completed form to ROI@infirmaryhealth.org or mail to: Infirmary Health Attn: Health Information Management 5 Mobile Infirmary Circle Mobile, AL 36607	
12. Signature: _____ 13. Date Completed : ___/___/___	
OFFICE USE ONLY: Nature of Disposition: _____ Further Action indicated by requestor: YES _____ NO _____ If yes, indicate: _____ Date of Disposition: _____	