BERKS COUNTY

CLIENT REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Client Name: _____

Client ID #: _____

Date of Birth: _____

Today's Date: _____

1. The information to be amended is from:

   ☐ Medical Record

   ☐ Other; Please describe: _____

2. Date(s) of entry:_____

3. Reason for request:

   ☐ Incorrect Information ☐ Outdated Information

   ☐ Incomplete Information ☐ Other

   _____

   _____

4. What should the entry say to be more accurate?

   _____

   _____

5. Please list anyone who has received or relied on the information.

   Name Address

   a. _____

   b. _____

Signature of Client or Legal Representative:_____Date:_____

FOR OFFICE USE ONLY:

Amendment has been: Accepted: _____
Denied: _____

If **Denied**, check the reason for decision:

_____ The information was not created by this Office

_____ The information is not part of the client's designated record set

_____ Federal law does not allow making the information available to the resident for inspection

_____ The information is accurate and complete

Berks County Staff Comments

_____

_____

_____

Signature _____ Date:_____

Print Name & Title_____