Phoenixville Hospital • 140 Nutt Road • Phoenixville, PA 19460-3906

Patient Name (Print)	Date of Birth	MRN (Facility)
Address	Home Phone Number	Work Phone Number

After review of my medical record, I do not feel the original documentation is accurate. I wish to add information in the form of an addendum to the medical record.

Service Date(s):

I'm amending my medical record by adding the following information:

I understand the care team may or may not supplement the medical record with an addendum based on my request. They, under no circumstance, can alter the original documentation of the medical record. This request for an amendment will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

These are the organizations that I want to be informed of the requested amendment:

Name	Name
Address	Address
City, State, Zip	City, State, Zip

I understand that by listing the name and addresses of other organizations on this Amendment form, I am asking Phoenixville Hospital to take reasonable steps to disclose the requested amendment to these organizations. I therefore give permission to Phoenixville Hospital to share the amendment with these organizations. In addition, I understand that Phoenixville Hospital may be required to send this amendment to its business associates and other organizations that need to know about this amendment. I give permission to send the requested amendment to those organizations identified by Phoenixville Hospital as needing the amendment.

Note: If you have additional names, please attach an additional sheet to this page.
My signature below signifies that I agree to the above terms.

Print Patient Name	Date of Birth
Patient Signature or Authorized Representative	Date

Request to Amend Protected Health Information

White - Director, Health Information Management
Yellow - Patient

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