Williams College

Request for Amendment of PHI

Date of Request: _____

Name: _____

Social Security Number:_____

Address_____

Phone Number (H)_____(W)_____

I understand that the health plan may or may not supplement the medical record with an addendum based on my request and under no circumstances is able to alter the original documentation of the medical record. This request for an amendment by means of an addendum may be made part of my permanent health plan record and will be sent to individuals/organizations identified below as having relied on the content of my health plan record.

Describe the information you want amended (e.g., claims records, health plan notes)

_____
_____
_____

Date(s) of information to be amended (e.g., date of claim, date of treatment or other health care service) _____

What is your reason for making this request?

_____
_____
_____

What information or data in the record would you like to add, change, or delete?

_____
_____
_____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other health care provider)? **yes no (circle one)**

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

_____
_____
_____
_____

Signature of individual requesting amendment _____