Form #: CP 01
Owner: Compliance & Privacy

Request for Amendment of Protected Health Information

Patient Name: ____

Patient MRN:______________________ Patient Date of Birth:______________

Patient Mailing Address:____

____

Date of Request: ______________________ Date of Service:______________________

Name of Requestor if Different from Patient: ______________________________

Phone number of Patient/Requestor:______________________________________

Location: D Children's Hospital ◻Touro Infirmary ◻Other

D West Jefferson Hospital ◻New Orleans East Hospital

D University Medical Center ◻East Jefferson General Hospital

Individuals have the right to request amendments of their protected health information (PHI) in the Organization's designated record set. Please complete the following so that we can timely process your request:

1. Describe PHI requested to be amended (e.g., medical record, lab results):

   ____

   ____

   ____

   Attach additional sheets as necessary

2. Dates of the information to be amended (date of office visit, date of procedure, other services):

   ____

   ____

   Attach additional sheets as necessary

3. What is the reason for requesting amendments?

   ____

   ____

   Attach additional sheets as necessary

4. How should the records be stated, i.e., what are the requested amendments?

   ____

   ____

   Attach additional sheets as necessary

5. Submit this completed and signed form to the LCMC Health Compliance Department via mail or email at the following address:

LCMC Health Compliance Department
1100 Poydras St. Suite 2500
New Orleans, LA 70163
compliance@lcmchealth.org

Signature of Requestor______________________________ Date______________