# Request for Amendment of Protected Health Information

| | |
|---|---|
| **Patient Name:** | **Patient MRN:** |
| **Patient Date of Birth:** | **Patient/Requestor Phone Number:** |
| **Patient Mailing Address:** | **City, State, Zip Code:** |
| **Name of requestor (if different from patient):** | |
| **Relationship to patient:** | |

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, attaching additional sheets corresponding to the questions as necessary. Submit this completed and signed form to the LSU Healthcare Network Compliance Department via mail or email to: **LSU Healthcare Network, Compliance Department, 478 S. Johnson Street, New Orleans, LA 70112 email: HNCompliance@lsuhsc.edu**

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

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

3. **What is the reason for requesting amendments?**

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

**Signature of Requestor**_____ **Date**_____