



**REQUEST TO AMEND PROTECTED HEALTH INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_  
*(filled out by hospital)*

Please tell us what protected health information you want changed:

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Please tell us why you want this change. You must give a reason:

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**NOTE:** We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide

If we decide to change the health information as you requested, we will send you a letter informing you of our decision.

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.



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4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

Tell us where to send you a letter:

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\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

When you have finished filling out this form, please send or bring the form to:

ATTN: Health Information Management  
Community Hospital of the Monterey Peninsula  
PO Box HH  
Monterey, CA 93942

For more information about your privacy rights, see the “Notice of Privacy Practices” available on our website at [www.chomp.org](http://www.chomp.org) or at Risk Management and Privacy at Community Hospital of the Monterey Peninsula or by sending a written request to:

ATTN: Risk Management and Privacy  
Community Hospital of the Monterey Peninsula  
PO Box HH  
Monterey, CA 93942

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact the Privacy Officer at 831-622-2620 or email [PrivacyOfficer@chomp.org](mailto:PrivacyOfficer@chomp.org). All complaints must be submitted in writing.

*You will not be penalized for filing a complaint.*