

**REQUEST TO AMEND PHI – Form #8**

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

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

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

Please tell us what protected health information you are requesting be amended. Be as specific as possible and document the report or form that the information is on.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us why you want this amendment and give a reason.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We must tell you within 60 days if we will amend your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide. Tell us where to send you a letter:

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

Address \_\_\_\_\_

\_\_\_\_\_

City, State, Zip \_\_\_\_\_

Give a phone number so we can call you: \_\_\_\_\_

If we decide to amend the health information as you requested, we will send the amendment to any person who received the information before it was amended. Tell us if there are any additional persons who need the amended information:

No. Initials: \_\_\_\_\_

Yes. Please list the persons' names and addresses:

Persons' Name	Persons' Name
Address	Address
City, State, Zip	City, State, Zip

We will also send the amendment to other persons that we know received the information before it was amended **if they relied, or might in the future rely**, on the information to your detriment (harm). Do you agree to this?

No. Initials: \_\_\_\_\_

Yes. Initials: \_\_\_\_\_

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

1. We did not create the information. Exception: if the person who created the information is unavailable to act on your request to amend it, we may consider your request if we are able to verify this information. For example, the doctor who originally created the information has died and you have no other way to obtain the amendment. If this exception applies to you, please explain:

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

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For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website [www.torrancememorial.org](http://www.torrancememorial.org) or at the Health Information Management Department.

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact the Privacy Officer in the Health Information Management Department at 310-517-5721. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Signature of Patient or Representative:
If Representative, give relationship:
Date:

When you have completed this form, please bring it to the Health Information Management Department at Torrance Memorial Medical Center or mail it to:

Health Information Management Department  
Torrance Memorial Medical Center  
3330 Lomita Blvd.  
Torrance, CA. 90505  
310-517-4723