Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH

PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Rights-P
HIPAA Privacy Patient Rights

IDN13150017

INSTRUCTIONS: As a patient, you have the right to request that Rush change or amend your protected health information in the medical record that Rush maintains. Rush may approve or not approve the request under certain circumstances.

Patient Information – please provide us with the following information about the patient:

Last Name	First Name	Middle Name
Street Address	City	State
Zip Code	XXX-XX- _____ Last 4 SSN	Date of Birth
Patient Signature	Date of Request	Phone Number

Personal Representative – if you are the patient's personal representative, please provide your information below:

(Note: If a personal representative is making this request, please attach certifying documentation of your status as the personal representative, such as a Power of Attorney or Guardianship papers).

Last Name	First Name	Middle Name
Personal Representative Signature	Date of Request	Relationship to Patient

Specify the records you wish to amend and the amendments you wish to make:

_____ Lab results _____ Billing _____ Date of Service

_____ Treatment information _____ Other: (please explain): _____

State the reasons for the amendment request (Please attach additional comments in another page if necessary):

_____

_____

_____

_____

_____

When completed, please return this form to:

Rush, ATTN: Privacy Office, 707 South Wood St., Suite 317, Chicago, IL 60612-3833

Telephone: (312) 942-5303 • Fax: (312) 942-6875