


<p>Patient Name: _____</p> <p>Date of Birth: _____</p> <p>Medical Record#: _____</p> <p>Place Patient Label</p>	<div><p>Rush Copley Medical Center</p><p><b>PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION</b></p></div>
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**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
_____	X X X – X X -	_____
Zip Code	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:**

<input type="checkbox"/> Lab Results	<input type="checkbox"/> Billing	<input type="checkbox"/> Date of Service
<input type="checkbox"/> Treatment Information	<input type="checkbox"/> 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