REQUEST TO CORRECT/AMEND ePHI FORM
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If you believe that the protected health information contained in your electronic medical record ("ePHI") is in error or that it needs to be amended, you have the right to request a correction/amendment to it. To do so, please complete, sign, and submit the attached *Request to Correct/Amend ePHI*. The request form and any subsequent information pertaining to the request will become a part of your permanent electronic record.

Millennium will consider all appropriately submitted *Requests to Correct/Amend ePHI*. Please note that Millennium is not required to make corrections or amendments if your Physician/Provider feels that the information is valid and an appropriate part of your ePHI. Your Physician/Provider, the Practice/Operations Manager and/or Millennium's Privacy Officer will review and process your request and will notify you in writing as to the approval or denial of the request within sixty (60) calendar days of receipt of the complete, accurate and signed *Request to* Correct/Amend *ePHI* form.

INSTRUCTIONS:
Print the attached *Request to Correct/Amend ePHI* form or ask your Physician/Provider's staff to print the form for you. (Note: you may be asked to show Photo ID to obtain the form in person.) Using dark permanent ink, PRINT LEGIBLY and COMPLETE all fields. Mail or hand deliver the completed form to you Physician/Provider's office.

PROCESS:
1. Staff will alert the Practice/Operations Manager and document receipt of the completed form.
2. Without delay, Practice/Operations Manager will document the Request to Correct/Amend ePHI through the ICRS System.
3. Without delay, Practice/Operations Manager will review the request with the Provider.
4. Physician/Provider will make a determination to accept or to deny the Correction/Amendment.
5. Privacy Officer will notify you by mail of the Physician/Provider's determination within 60 days of receipt of appropriately submitted *Request to Correct/Amend PHI* form.
6. **If the correction/amendment has been accepted**, the amendment will become part of your permanent record. If you have authorized Millennium to release any corrected/amended information, Millennium will make reasonable efforts to send amended/corrected information to parties that you indicated on the form.
7. **If the correction/amendment has been denied**, you may
    a. Submit to Millennium's Privacy Officer a written *Statement of Disagreement* which will be maintained in your medical record; or
    b. Submit to Millennium's Privacy Officer a written *Request for Appeal.*
8. **If your appeal is ultimately denied**, you may
    a. Submit to Millennium's Privacy Officer a written *Statement of Disagreement* which will be maintained in your medical record; or
    b. Seek judicial review of the decision
9. Millennium has the right to prepare and provide you with a written rebuttal to any *Statement of Disagreement*. This rebuttal will not be subject to correction or amendment by you.

Should you have a complaint about Millennium's policy and procedures concerning health information, you may file such a complaint to the following: Millennium's Privacy Officer, or, the Department of Health and Human Services, Office for Civil Rights, or Secretary, Department of Health and Human Services.

Patient Name:	**D.O.B.:**	**Date:**

The information to correct/amend was entered into my medical record on _____ (mm/dd/yyyy).
The information should be corrected/amended as follows:

_____

_____

_____

_____

_____

(Use additional sheets if necessary and attach to this form. Please write full name and date of birth on each additional page.)

Upon your approval, Millennium Physician Group will make a reasonable effort to provide the amendment to other persons whom Millennium knows to have received the original information and who may have relied on, or are likely to rely on, such information in a manner that may be detrimental to your health. (Check if applicable.)

□ Millennium has my approval to release any amended information to individuals or entities as described above.

Upon your approval, Millennium Physician Group will release the amended information to individuals or entities that you specify below.

□ Millennium has my approval to release amended information to the following individuals or entities named below.

_____	_____	_____
Name	Street Address	City/State/Zip
_____	_____	_____
Name	Street Address	City/State/Zip

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative (if applicable): _____