



1500 Forest Glen Road  
Silver Spring, MD 20910-1484  
301-754-7000  
HolyCrossHealth.org

## REQUEST TO AMEND OR CORRECT HEALTH INFORMATION HELD BY HOLY CROSS HEALTH

Name of requesting individual: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (M.I) MM/DD/YYYY

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

Social Security #: \_\_\_\_\_ Date of birth \_\_\_\_\_ Date of Service \_\_\_\_\_  
(Optional) (MM/DD/YYYY)

Describe the amendment or correction that you wish us to make:

\_\_\_\_\_

Describe why you think the amendment or correction that you are requesting is appropriate or necessary:

\_\_\_\_\_

Identify any other persons or entities you believe have received your health information and need to be notified of the amendment/correction that you are requesting.

\_\_\_\_\_

### Information about Your Amendment/Correction Rights

We will not process your request for an amendment/correction of your health information if it is not made in writing on this Form or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if extra time is needed), and will inform you in writing as to whether the amendment will be made or denied.

We may deny your request if you ask us to amend information that:

- Was not created by Holy Cross Health, unless the person who created the information is no longer available to make the amendment;
- Is not part of the information Holy Cross Health keeps about you;
- Is not part of the information that you would be allowed to see or copy; or
- Is determined by us to be accurate and complete.

If we deny your request amendment, we will tell you in writing how to submit a statement of disagreement or a complaint, or to request that we include your amendment request in your health information that we maintain.

By submitting this form, I hereby request Holy Cross Health to amend or correct my health information, as described above that Holy Cross health maintains.

I understand that if Holy Cross Health agrees to my request, they will provide the amendment/correction to relevant third parties, including, but not limited to, the individuals I identified in #5 above and third parties with Holy Cross Health contracts to provide services to or on behalf of Holy Cross Health.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Workforce member who received this form

\_\_\_\_\_  
Date form received

We have reviewed your request for Holy Cross Health to amend your health information and have determined that Holy Cross Health will grant your request.

Holy Cross Health has reviewed your request to amend your health information and has determined that it must deny your request. Reason for Denial \_\_\_\_\_