COLUMBUS REGIONAL HOSPITAL
COLUMBUS REGIONAL HEALTH PHYSICIANS, LLC
Request for Amendment of Health Information

Patient Name:_____ **Request Date**:_____

Street Address:_____ **Birth Date**:_____

City / State / Zip:_____ **MR/Acct. #**:_____

What Needs To Be Amended And Why

Entry to be Amended:_____

Date & Author of Entry:_____

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual (name and address):

I understand that Columbus Regional Hospital (CRH) or Columbus Regional Health Physicians, LLC (CRHP) are not obligated to amend the record but will review the request. I understand that my request will be processed within 60 days, unless you are notified in writing of the need for a 30 day extension.

_____ _____

Signature of Patient / Legal Representative / Relationship to Patient | Date of Request

Please submit the completed form via:

US Mail: Columbus Regional Hospital
Attention: Privacy Office
2400 E. 17th Street, Columbus, IN 47201

Email: privacyofficer@crh.org

In Person: At the office where you received services or to the Columbus Regional Hospital, Health Information department located at Entrance 3, near the patient registration desk.

FOR HOSPITAL USE ONLY

Date Received:_____ ☐ Accepted ☐ Denied

_____ _____ _____

Signature of Record Author/Reviewing Clinician | Title | Date

_____ _____

Signature of Privacy Officer | Date

If Denied, check Reason for Denial:

☐ PHI was not created by Columbus Regional Hospital

☐ PHI is not part of the patient's designated record set

☐ PHI is accurate and complete

Comments:

☐ Individual was informed of denial in writing (attach letter)

_____ _____

Signature / Title | Date

☐ Individual has requested in writing the amendment/denial be included with any future disclosures of PHI (attach request)

_____ _____

Signature / Title | Date

Doc type: Request for Amendment

MR-160 (03/21/2025) 2/p: Drill/2

COLUMBUS REGIONAL HOSPITAL
2400 EAST 17TH STREET, COLUMBUS, IN 47201
800.841.4938 812.379.4441
crh.org

Request for Amendment of Health Information

PATIENT LABEL
OR
Patient Name:_____
DOB:_____/_____/_____
MR #: _____