St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177

Tel: (340)775-3700
Fax: (340)777-7927

"Your Health is our First Priority"

Amendment Request Form

Patient Name: ____________________________________ Date of Request: _______________

Pt # ______________ Date of Birth: __________________ Phone # _______________________

You have the right to request corrections or amendments to Personal Health Information we retain on your behalf if you believe something in that information is in error or needs to be amended. St. Thomas East End Medical Center Corporation is not always required to make the corrections or amendments you request but each request will be carefully reviewed, and corrections or amendments made if warranted. You will be notified when your request has been approved or denied. Please provide as much detail as possible regarding the record type, the location, the date, and the problem. For instance, "My laboratory test results from ABC laboratory of December 5, 2000 show a blood test I never received" or "Dr. Jones in your North Street Clinic recorded in my record on December 5th, 2000 that I was suffering from weakness in my right leg when in fact the weakness was in my left leg" In order to review the requested correction, we must be able to locate the record in issue and the exact entries or reports you want corrected.

Please state as precisely as possible how you would like to see the record worded.

If you are aware of any of your health care providers who may have a copy of the record you seek to have corrected, please list those persons and/or facilities with as much information you have available regarding names and address.

Name: ____________________
Address: ____________________
City: ____________________
State: ____________ Zip Code: ____________
Phone: ____________________
Information Request:

Name: ____________________
Address: ____________________
City: ____________________
State: ____________ Zip Code: ____________
Phone: ____________________
Information Request:

I hereby authorize the St. Thomas East End Medical Center Corporation to provide a copy of the corrected/amended records with the persons/entities I have listed above.

Signature: ______________________________ Date: ____________________

Please print relationship to patient (if signed by a personal representative of patient):

____

Mail or email the completed signed form to: Attention: Privacy Officer
St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177
Email: privacyofficer@steemcc.org

OFFICIAL USE

PT# ____________________

The amendment has been:	☐ Approved	☐ Denied
If denied, check reason for denial.	☐ PHI is not part of the patient's designated record set.	☐ Record is not available to the patient for inspection under Federal Law.
	☐ STEEMCC did not create record.	☐ Record is accurate and complete.
	☐ Other ____________________	

Medical Director: ______________________________ Date: ____________________

Privacy Officer: ______________________________ Date: ____________________