

Please fill out the following form and return this form to:
ATTN: Health Information Management Department
Northwest Community Hospital
800 W. Central Road
Arlington Heights, IL, 60005
(847) 618-3200

I, _____, request Northwest Community Healthcare (NCH)
to amend my health information in the manner set forth below.

The specific portion of my health information that I desire NCH to amend is the following (please be specific to where this information is located in the chart):

I request that the health information records listed above be amended by appending the following information:

I am requesting that NCH amend my health information for the following reason(s):

I believe that the following persons or organizations may hold my health information, which needs to be amended according to this request for amendment, (please list names, addresses and telephone numbers):

My contact information is:

Name: _____

Date of Birth: _____

Address: _____

Telephone Home: _____ Work: _____

Signature: _____

Printed Name: _____

Northwest Community Healthcare
Arlington Heights, IL 60005

**REQUEST TO AMEND PROTECTED
HEALTH INFORMATION**

For HIM Department Use Only

Received by: Signature: _____

Print Name: _____

Received on: Date: _____

Method of Receipt: _____
(for example U.S. mail, hand delivery, etc.)

Final Disposition:

Signature: _____ Date: _____

Northwest Community Healthcare
Arlington Heights, IL 60005

**REQUEST TO AMEND PROTECTED
HEALTH INFORMATION**