REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

<table>
<thead>
<tr>
<th>PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME</th>
<th>SIGNATURE</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
</table>

If Personal Representative has signed above, please indicate your relationship to the patient:

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Agent
- ☐ Other

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

I hereby request that City of Hope National Medical Center amend [please check all boxes that apply]:

- ☐ My medical records
- ☐ My billing records

All as more specifically described below:

I understand that City of Hope National Medical Center may deny this request as permitted under law. I further understand that if City of Hope National Medical Center denies my request, I will be informed in writing by City of Hope National Medical Center of its reason for the denial and what I should do if I disagree with the denial. I further understand that City of Hope National Medical Center will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If City of Hope National Medical Center is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results).

2. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services).

3. What is your reason for making this request?

4. How is the entry incorrect, incomplete, or outdated?

5. What should the entry say to be more accurate or complete? (Please be as specific as possible)

6. Do you know of anyone who may have received or relied on the information in question (such as: your doctor, pharmacist, health plan, or other health care provider)? □ Yes □ No

If yes, please specify the name(s) and address(es) of the organizations or individual(s):

Form No. 8610-C029 Revised: 01/28/11 RAPHI Photocopy: Patient Page 1 of 2
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

FOR CITY OF HOPE NATIONAL MEDICAL CENTER USE ONLY

Amendment has been: □ Accepted □ Denied

If denied, check the reason for denial:

□ Protected Health Information was not created by City of Hope National Medical Center.

□ Protected Health Information is not accessible by the patient under City of Hope National Medical Center’s policy regarding the patient’s right to access his or her Protected Health Information.

□ Protected Health Information is accurate and complete.

Comments:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

COHNC REPRESENTATIVE PRINTED NAME    SIGNATURE    TITLE    DATE    TIME

Form No. 8610-C029    Revised: 01/28/11    RAPHI    Photocopy: Patient    Page 2 of 2