REQUEST FOR AMENDMENT OF HEALTH INFORMATION

PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 15

1. Today's Date

2. Patient's Name

3. Patient's Date of Birth

4. Patient's Medical Record Number (if known)

5. Patient's Social Security Number

6. Describe the information you are requesting to amend: _____

_____

7. Date(s) of the information you are requesting to amend: _____

8. What is the reason for this request? _____

_____

9. Is the information you are requesting to amend **Incorrect** **Outdated** **Other** (please explain)_____

_____

10. What should the information state to be more accurate or complete? _____

_____

11. Who, if anyone, received or relied upon the information in question (example: doctor, pharmacist, health plan, etc.)?

_____

12. Signature of Patient or Legal Representative

13. Date

14. Printed Name of Patient's Legal Representative

15. Relationship to Patient

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

17. The amendment has been: **Accepted** **Denied**

18. If denied, indicate reason for denial (please check appropriate box):

Medical Record was not created by this organization
Information to be amended is not part of the patient's designated record
Federal Law prohibits making the question available to the patient for inspection (i.e. psychotherapy notes)
Other (please explain):_____

Signature of Authorized Individual

Date

Printed Name of Authorized Individual