Request to Correct or Amend Health Information

Attn: Medical Records Department

Patient Name:____ **Date of Birth**____________________

Previous Name:____ **SS#:**____________________

Patient Mailing Address:____

☐ I request a change to my records.

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record:**____________________

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Patient or legally authorized **Date**

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Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

We will review your request and respond within 10 days of receiving your request. A copy of your request will be added to your record.

We will send changes to:

☐ anyone you identify, and

☐ anyone who received the information in the past and who needs to know about the change.

<u>To be completed by the Health Care Provider</u>

Date Received:_______________Correction/Amendment has been: ☐ **Accepted** ☐ **Denied**

☐ The review of this request for correction/amendment has been delayed. Your request will be processed by the following date:_______________ (not later than 60 days after the request).

If denied, check reason for denial:

☐ The existing health information is accurate and complete.

☐ This request does not pertain to the patient's medical and financial records.

☐ Due to federal and state laws this health information is not available.

☐ This health information was not created by this organization.

☐ The record no longer exists or cannot be found.

☐ The record is not maintained by this organization.

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Name of reviewing provider or position Date