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REQUEST FOR AMENDMENT OF A MEDICAL RECORD

A patient or legally authorized representative who believes information in the patient's health record is incomplete or incorrect, may request an amendment to the record.

Patient Name	Date of Birth
Address to which response should be sent:	Telephone #
Verification of Identity	Medical Record Number

** Complete the following only if the person making the request is not the patient:

Name of Requestor	Relationship to Patient	Legal Authority
Verification of Identity	Verification of Authority	

Complete all areas below with as much detail as possible:

Date(s) of entry or entries to be amended:	
Name of the report or type of entry:	
Explain how the entry is incorrect or incomplete.	
How should the entry be worded to be correct or more complete?	

If this amendment is approved, would you like the corrected information sent to anyone who may have received the information in the past? *(Circle one)* **Yes** **No** If yes, please specify the name(s) and address(es) of the person(s) or place(s). (Use the back for more names, if needed.)

______________________ Name	______________________ Name
______________________ Address	______________________ Address
______________________ Address	______________________ Address

I certify that the information above is correct to the best of my knowledge.

Date: _______________ Signature: ________________________________

Staff Use Only

This request was reviewed on______________ by ______________________________
Date Name and Title

_____ The request was approved and the amendment described above was appended to the record.

_____ The request was approved in part: Explanation is attached.

_____ The request was denied: Denial of Amendment is attached.

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