REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete the following:

1. Today's Date:_____

2. Patient Full Legal Name:_____

3. Birth Date:_____ Patient Medical Record Number:_____

4. Patient Mailing Address:_____

   City:_____ State:_____ Zip Code:_____

5. Describe the information you want added/removed/changed, please use additional pages if needed. (e.g. lab test results, physician notes)

   _____

6. Date(s) of the information you want corrected (e.g. date of office note, treatment or other services)

   _____

7. What is your reason for making this request?_____

8. How is the entry incorrect or incomplete?_____

9. **Please attach a written statement.**

10. 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 healthcare provider)? If yes, please specify the name(s) and address(es) of the organization or individual.

    _____

    _____

11. If we agree to your request, do we have permission to share the new information with the individuals who have already received the original information? ☐ YES ☐ NO ☐ N/A

    Signature of Patient/Legal Representative:_____

    Relationship to patient (e.g. self, mother, POA):_____

    Date:_____

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Request for Amendment has been: Approved ☐ Denied ☐ Signature of Privacy Official Designee:_____ Date:_____

____Patient has not filed a Statement of Disagreement, but requests that any future releases include the requested amendment & denial information.
____Patient has filed a Statement of Disagreement that MUST be released along with other documentatin with any future release.
____Facility/Provider appended written response (rebuttal) and forwarded to patient.
____Facility/Provider did not approve a response/rebuttal.