



Request for Amendment of Health Information

Last Name: _____ First Name: _____ Middle Initial _____

Date of Birth: _____ Social Security # _____

Phone Number: _____ Email: _____

I understand the health care provider may or may not supplement the medical record with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical record. This request for an addendum may be made part of my permanent medical record and will be sent to individuals / organizations identified below as having relied on the content of my medical record.

Describe the information you want amended (e.g., evaluation, daily notes) _____

Date(s) of information to be amended (e.g., date of office visit, treatment, or other healthcare service). _____

What is your reason for making this request? _____

What would you like to add / change to the record? _____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other healthcare provider)? YES NO

If yes please specify the name(s) and address (es) of the individual(s) or organization(s). _____

Signature

Date

FOR HEALTH CARE ORGANIZATION USE ONLY

Amendment has been ACCEPTED DENIED

If denied, check reason for denial:

- Health information was not created by this organization
 - Health information is not part of the patient's designated record set.
 - Federal law forbids making the health information in question available to the patient for inspection (e.g., psychotherapy notes)
 - Health information is accurate and complete
 - Originator of the record is not available because: _____
-

Comments _____

THE INFORMATION SECURITY OFFICER MUST REVIEW ALL DENIALS

Date denial letter was sent to individual: _____

Signature of Staff Person