



Request for Amendment of Health Information

Patient/Resident to complete the following information.

Date: _____

Patient/Resident Name: _____

Birth Date: _____

Patient/Resident Address: _____

Telephone #: _____

Med. Rec. #: _____

REQUEST:

I hereby request Regional Medical Center/Regional Family Health to amend the following (check all that apply)

My medical records

My billing records

Other—please describe _____

Dates of information to be amended (eg—date of visit, treatment, or other health care services) _____

The information is incorrect or incomplete in the following manner: _____

I request this amendment for the following reason(s): _____

The information should be amended as follows: _____

I would like this amendment sent to the following persons who may received my health information in the past—(please specify the name and address of the individuals or organizations):

I understand that Regional Medical Center/Regional Family Health may or may not supplement the medical record with an addendum based on my request. I also understand that Regional Medical Center is not able to alter the original documentation in the medical record under any circumstances. Regardless whether my request is granted or denied, I understand that this request will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for release of my health information.

Signature of patient/resident or legal representative _____

Printed name of legal representative _____

Relationship to patient/resident _____

Regional Medical Center/Regional Family Health to complete the following :

Date of Receipt of Request _____

Request for correction/amendment has been: Accepted Denied

If denied, check reason for denial:

 The PHI was not created by Regional Medical Center

 The PHI is not part of the patient/resident's designated record set

 The PHI is not available to the patient/resident for inspection as required by Federal Law (e.g./psychotherapy notes)

 The PHI is accurate and complete

Staff Comments _____

Notice to Patient/Resident/Others

Patient/resident or other notified of determination via one or more of the following (check all that may apply):

Attachment A (Notice of Acceptance of Amendment) sent to patient/resident on _____.
(Date)

Attachment B (Notice of Denial of Amendment) sent to patient/resident on _____.
(Date)

Attachment C (Notice of Acceptance of Amendment) sent to identified persons pursuant to patient/resident authorization on _____.
(Date)

Signature of staff member _____ Date _____

Print name and title _____