Regional Medical Center®
709 West Main St.
P.O. Box 359
Manchester, IA 52057
563-927-3232
FAX 563-927-7577
www.regmedctr.org

# Request for Amendment of Health Information

Patient/Resident to complete the following information.

Date: _____

Patient/Resident Name: _____

Birth Date: _____

Patient/Resident Address: _____

Telephone Number: _____ Medical Record Number: _____

REQUEST:

I hereby request Regional Medical Center, Regional Family Health, Regional Medical Home Care and Hospice of Comfort 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 have 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, Regional Medical Home Care or Hospice of Comfort may or may not supplement the medical record with an addendum based on my request. I also understand that Regional Medical Center, Regional Family Health, Regional Medical Home Care or Hospice of Comfort 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: _____

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Regional Family Health, Regional Medical Home Care or Hospice of Comfort 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: _____