



REQUEST FOR AMENDMENT OF HEALTH INFORMATION

PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 15

1. Today's Date _____

2. Patient's Name _____

3. Patient's Date of Birth _____

4. Patient's Medical Record Number (if known) _____

5. Patient's Social Security Number _____

6. Describe the information you are requesting to amend: _____

7. Date(s) of the information you are requesting to amend: _____

8. What is the reason for this request? _____

9. Is the information you are requesting to amend **Incorrect** **Outdated** **Other** (please explain) _____

10. What should the information state to be more accurate or complete? _____

11. Who, if anyone, received or relied upon the information in question (example: doctor, pharmacist, health plan, etc.)?

12. Signature of Patient or Legal Representative _____

13. Date _____

14. Printed Name of Patient's Legal Representative _____

15. Relationship to Patient _____

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

17. The amendment has been: **Accepted** **Denied**

18. If denied, indicate reason for denial (please check appropriate box):

Medical Record was not created by this organization

Information to be amended is not part of the patient's designated record

Federal Law prohibits making the question available to the patient for inspection (i.e. psychotherapy notes)

Other (please explain): _____

Signature of Authorized Individual _____

Date _____

Printed Name of Authorized Individual _____