Attachment A
REQUEST FOR CORRECTION/AMENDMENT OF HEALTH INFORMATION

Patient Name_____ Date of Birth_____

Patient Address_____

Patient Telephone Number_____

Date of Entry to be Amended_____

Type of Entry to be Amended_____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (Prefer a copy of the document to be amended with highlighted or written changes.)

_____
_____
_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

_____
_____
_____

In addition to sending this correction/amendment to the individual(s) or organization(s) you've listed above, we will also furnish this information to others you may not have listed that have the previous information and could otherwise rely upon it to your detriment.

_____ _____
Signature of Patient or Legal Representative Date

For Healthcare Organization Use Only:

Date Received_____
Amendment Denied_____
Accepted_____
Denied in Part _____

If denied or denied in part, check reason for denial:
__ Is accurate and complete
__ Not created by this organization
__ Not available to the patient for inspection
__ Not part of patient's designated record set

_____ _____
Name of Staff Member Title

_____ _____
Signature Date

Send requests to Medical Records owner via confidential fax, e-mail, or interoffice mail.

1836 **REQUEST FOR CORRECTION/AMENDMENT OF HEALTH INFORMATION** BC 0891 11/12	**PATIENT**