Print Clear

Patient Information

Full Name _____ Medical Record # _____

Address/City/State/Zip _____

Date of Birth _____ SS # _____ (last four digits) Fax # _____

Day Phone # _____ Evening/Cell Phone # _____

Request for Amendment

After reviewing my medical record, I am requesting an amendment to my medical record for treatment that was provided to me on _____, 20____. The reason(s) for this request are detailed below:

Reason(s) for Amendment: _____

_____

_____

Information

- I am formally requesting that my medical record be supplemented with clarifying information in the form of an Amendment to the medical record.
- I understand that the provider/author who made the entry may or may not agree to supplement the medical record with an Amendment based on my request.
- I also understand that under no circumstances is the provider/author permitted to alter the original documentation in the medical record; this means that the author cannot erase, delete, cover over or otherwise change what has already been written or typed.
- I understand that if my request for Amendment is denied, I can file a statement of disagreement.

PHI Amendment

I request the following Amendment be made to my record: ☐ See attached

_____

_____

_____

Notification

If the request for Amendment is accepted, please notify the providers listed of the Amendment (include name and full address; attach additional pages, if needed):

_____

_____

Signature

_____

Signature of Patient/Guardian/Personal Representative Relationship Date

Response to Request

***For SCL Health use only:* Response to Request for Amendment**

☐ In response to your request, an amendment **WAS** made part of your permanent record as described below:

_____

_____

☐ In response to your request, an amendment **WILL NOT** be made part of your permanent record based on the reason(s) indicated below. The documentation:

- ☐ was not created by an SCL Health Entity
- ☐ is not available for inspection by the individual
- ☐ is not part of the Designated Record Set
- ☐ is accurate and complete

Comments: _____

Signature _____ Title _____ Date _____

SCL Health

ON046

Request For Amendment of Protected Health Information (PHI)

EH-FR-MR-0258-1019-SCLHS

SCL HEALTH USE ONLY

- ☐ Date form mailed to patient _____
- ☐ Date form received from patient _____
- ☐ Date copy mailed to patient _____
- ☐ Date copy mailed to relevant individuals _____
- ☐ Date changes made to medical record _____
- ☐ Date all actions completed _____

_____

HIM/Privacy Officer Signature Date