



Patient Label Or Print Name/DOB

Patient Name: _____

DOB: ____/____/____ MR# _____

Account # _____

Request for Amendment to the Medical Record Form

Patient's Name _____

Date of Birth: ____/____/____

Patient's Address _____

Date of Service: ____/____/____

Phone # _____

You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete. The amendment would include the information you believe is in error, and your proposed corrections to that information. To request an amendment to your medical information, please fill out this form in its entirety. You may mail, fax or deliver the form and any supporting documentation in person.

Type of Entry(ies) or Report(s) to be Amended:

Date(s) of Entry(ies) to be amended:

Please explain the information that you believe to be incorrect or incomplete. Include what you feel would be exclude/included in order to make the record more accurate or complete.

If this amendment request is approved please specify the name(s) and address(s) of any organizations or individuals you would like us to send the amended information to.

I understand that this amendment request will become a part of my medical record. I understand that I will receive a response to my above request within 60 days or I will receive a request for an additional 30-day extension.

Signature of Patient

_____/_____/_____
Date:

Signature of Legal Representative

Relationship to Patient

_____/_____/_____
Date:



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Request for Amendment to the Medical Record Form

Practitioner Determination:

Accepted: Your requested addendum will be made to your permanent medical record.

Denied: Your requested amendment has been denied for the following reasons:

- The information was found to be accurate and complete
- The information you want changed was not created by Copley Hospital.
- Federal law does not permit you to inspect the information (for example, psychotherapy notes).
- The information is not part of your medical record at Copley Hospital.
- The information is compiled in anticipation of or for use in any civil, criminal or administrative action Or proceeding.

Reason for Practitioner/MD Denial: _____

If your Request is Denied:

- You have the right to submit a written statement describing why you disagree with the above denial decision OR
- You may request in writing that Copley Hospital provides this request for amendment and the denial with any future disclosures of your protected health information.
- You also have the right to file a complaint with the Secretary of the Department of Health and Human Services @ <http://www.hhs.gov/ocr/privacy/hipaa/complaints> or mail your complaint to Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509 F, HHH Bldg. Washington, DC 20201

_____/_____/_____
 Physician/Practitioner Signature Date

Patient Request Form was received on ____/____/____

Patient was informed of decision on ____/____/____ by Phone Call Letter Mailed: ____/____/____

_____/_____/_____
 Signature of HIM Manager Date

_____/_____/_____
 Signature of Compliance Officer Date