



Date Requested: _____

Please read the following and complete the information requested

Patient Name:	Date of Birth:	Medical Record Number (If known):
Mailing Address:		Phone Number:

If you believe that the protected health information the Hospital has on file about you is incorrect or incomplete, you have the right to ask us to correct the information in your records.

Please specify the document(s) with incorrect or incomplete information:

Name of the Document (Operative Report, History & Physical, Progress Notes, etc.)	Date of the Document	Author of the Document

Please check one (1) box to indicate what type of change you would like to make to your personal health information:

Addendum – you are requesting to include an additional statement into your medical record. Please provide your statement below in 250 words or less (you may attach additional sheets as necessary).

Amendment (Correction) – you are requesting the authoring clinician to make changes to your personal health information. Please explain below what changes you would like made and why you want this change (a reason must be given)

If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incorrect or incomplete. We must inform you within 60 days of receipt if we will change your protected health information as you requested, or inform you that we need more time (up to 30 additional days) to review your request.



AMENDMENT REQUEST

PATIENT LABEL

