HealthEast

Request for Amendment to Health Information

INDIVIDUAL TO COMPLETE

Name: ____ DOB: ______ - ______ - ______

Address: ____ Phone #: (_______) - ________ - ________

____

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?

____

____

____ ____

(Signature of Individual or Personal Representative) (Date)

____

(Relationship to Individual)

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

____ ____

(Name of organization or individual) (Address)

____

(City, State, Zip)

HEALTH INFORMATION MANAGEMENT (HIM) TO COMPLETE

Medical Record Number: _______________________________ Date Received: ________/_________/_________

Check reason for automatic denial:

- ☐ Health information is not part of the information kept by or for us.
- ☐ Health information was not created by us.
- ☐ Health information is not part of the information which you would be permitted to inspect and copy.
- ☐ The author of the health information is no longer available.

____ ________________________

(Signature and Title of HIM staff) (Date)

AUTHOR OF ENTRY TO COMPLETE

Amendment has been: ☐ Accepted ☐ Denied

The amendment to health information has been denied due to:

- ☐ Health information is accurate and complete.
- ☐ Other: ____

____ ________________________

Signature and Title of Healthcare Practitioner (Date)

Original – Medical Record **Copy - Individual**

MR9917C 3/17

DOC Type = Patient Request for Amendment