

REQUEST TO AMEND HEALTH INFORMATION FORM

Patient Name: _____ Date of birth: _____

Previous Name: _____

Patient Mailing Address: _____

I request a change to my records.

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of record:** _____

Patient or legally authorized individual signature *Date*

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

We will review your request and respond within 60 days of receiving your request. A copy of your request will be added to your record. If we make the change and you agree, we will send it to anyone we know has received the information in the past. We will also send the amendment to anyone you identify.

To be completed by [insert clinic/healthcare facility name]

Date Received _____ Correction/Amendment has been:
Accepted Denied - Letter Sent

Review of this request has been delayed due to _____.
Your request will be processed by the following date _____ (not later than 90 days after the request).

If denied, check reason for denial:

This health information was not created by this organization.

By law, this health information is not available to the patient and cannot be amended.

This request does not pertain to the patient's medical and financial records.

The existing health information is accurate and Complete.

Name of reviewing department or position

Date