

## REQUEST FOR AMENDMENT

Please complete the following:

1. Today's Date \_\_\_\_\_
2. Patient name \_\_\_\_\_
3. Address \_\_\_\_\_
4. Birth Date \_\_\_\_\_
5. Please describe the information you want amended (e.g., lab test results, physician notes)  
\_\_\_\_\_  
\_\_\_\_\_
6. Date(s) of information you want amended (e.g., date of office/clinic visit, treatment, or other health care services) \_\_\_\_\_  
\_\_\_\_\_
7. State your reason for making this request? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Describe how the entry is incorrect, incomplete, or outdated? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. What should the entry say to be more accurate or complete? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Do you know of anyone who may have received or relied on the information in question such as your doctor, pharmacist, health plan, or other health care provider?    yes    no  
If yes, please specify the name(s) and address(es) of the organization(s) or individual(s)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rev. May 2024



11. If your request for amendment is granted, do you give us permission to contact the persons identified in item 10 above so that they may amend the information also?

yes    no.

Name of Person Requesting Amendment (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If personal representative, relationship to patient: \_\_\_\_\_

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**FOR HEALTHCARE ORGANIZATION USE ONLY –**

*Please submit this form to Clinical Director*

Amendment has been:  Accepted     Denied

If denied, check the reason(s) for denial:

- the health information was not created by this organization.
- the health information is not part of the patient’s record.
- the law forbids making the health information in question available for inspection (e.g., psychotherapy notes).**
- the health information is accurate and complete.

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Compliance Officer Signature: \_\_\_\_\_

Date \_\_\_\_\_