

Medical Record Amendment Instructions

All requests to correct or amend documentation in your medical record must be submitted in writing to Health Information Management Chart Correction Unit.

- A. For correct, but outdated information, please contact your primary care physician or author of the information so it can be updated or reconciled. Examples include:
 - a. A medication you are no longer on
 - b. A condition you no longer have
- B. All other correction or amendment requests are processed by the Enterprise Health Information Management (HIM) Chart Correction Unit.

Steps for Patients to Request a Medical Record Amendment:

1. Request a copy of the portion of your medical record you believe is incorrect or inaccurate and an Amendment Request Form.
2. Review your medical records to confirm the information you want amended, removed or do not agree with. Notes are never deleted in their entirety, however incorrect information in the note can be corrected.
3. Complete the Amendment Request Form and provide as much detail as possible.
4. **Attach a copy of medical record documentation you believe to be incorrect. Make sure the erroneous information is highlighted as a reference and indicate what you think it should say whenever possible.**
5. Remember to keep a copy of the documents you send in to reference should we have additional questions.
6. Please return the Amendment Request Form and copies of all documentation to the address above.

Procedure once Chart Correction Unit receives your Amendment Request:

- The information will be processed and reviewed by the authoring clinician, who will determine the plan of action on the amendment. Please note the decision is not made by Chart Correction/Health Information Management.
- If approved by the provider, we will send you a copy of the amended documents and response.
- If denied by the provider, we will inform you in writing with the reason for denial and additional steps you can take.

Under federal regulations (HIPAA) the hospital must reply within 60 days of receipt of the completed form. In the rare instance we need more than 60 days, we will let you know in writing an extension is needed of no more than 30 days to complete the request.

If you have additional questions about this process, please call HIM Chart Correction at 857-282-9736.

REQUEST FOR AMENDMENT IN MEDICAL RECORD

Patient name: _____ Date of request: _____

Address: _____ Date of birth: _____

Contact telephone number: _____

*This section to be completed by patient. Additional pages may be attached if more space is needed.***I request the following information to be amended in my medical record:**

Date(s) of Entry to be Amended: _____

Description of Information to be amended: _____

Reason for request: _____

If possible, please enclose with this request copies of the specific information to be amended.

If your request is approved, we can provide copies to persons who received your protected health information who need to see the amendment. Please include name, title and mailing address for each:

If your request is denied:

- you may submit a statement disagreeing with the denial.
- you may request your original amendment request and/or your disagreement with the denial be attached to future disclosures of your protected health information.
- you may file a complaint with the institution or the U.S. Department of Health and Human Services.



I understand Mass General Brigham and/or its affiliated entities has deployed an integrated electronic medical record which is used by Mass General Brigham, its affiliated entities and healthcare providers and non-Mass General Brigham providers such as Dana-Farber Cancer Institute and certain community physicians and physician groups. I acknowledge by signing this form below I consent to and agree Mass General Brigham, Incorporated and its affiliated entities and healthcare providers and all other users of the integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute) may receive and process this amendment request all records stored within our integrated record system.

Patient/Guardian signature: _____

If Guardian, please print name: _____

Relationship: _____ Date: _____

The facility has 60 days to respond to the amendment request from the date of receipt. If the facility is unable to act on the request within 60 days, an extension of 30 days may be required. If an extension is required, notification will be provided along with a written explanation.

Return completed form to

Chart Correction Unit

Mail: 399 Revolution Drive Suite 970

Somerville, MA 02145

Fax: 857-282-5904

Email: HIMChartcorrection@partners.org

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