PARTNERS HEALTHCARE

Request for Amendment in Medical Record

Patient name: _____ Date of request: _____

Address: _____ Date of birth: _____

(This section to be completed by patient)

I request the following information to be amended in my medical record:

_____

_____

_____

Reason for request:

_____

_____

_____

Patient/Guardian signature:_____ Relationship:_____

(This section to be completed by Hospital or Doctor's Office)

Request approved: o yes o no Date of amendment: _____

Amendment made:

_____

_____

_____

Request denied: o yes o no

Reason for denial:

_____

_____

_____

Notification of amendment change/request sent to patient/designee:

_____

Privacy Officer/Correspondence Coordinator signature:_____ DATE:_____

If your request is denied:

- **you may submit a statement disagreeing with the denial**
- **you may request that your original amendment request and denial be attached to future disclosures of your personal health information**
- **you may contact Privacy Officer *(name & extension)***

If your request is approved, please list all relevant persons who we should notify of the change: Please include name, title and phone number.

_____

_____

_____

Note: 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.