pacific medical centers

Request for an amendment to medical record in designated record set

Original to be retained as permanent part of medical record

Instructions for requesting an amendment to your medical record
As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. We will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

To request an amendment to your demographic information (name, date of birth, address, etc.), you do not need to use this form. You may request the change by contacting us by phone or in person.

Please fill out all sections of this form.

Patient's Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SS#_____-_____-_____ Medical Record #_____

Address: _____City: _____State: _____Zip:_____

Day Phone: _____Cell Phone: _____Evening Phone: _____

ENTRY TO BE AMENDED:
Date of service: _____ Physician: _____

Explain how the documentation is incorrect or incomplete. (attach separate sheet, if necessary)

_____

_____

_____

I believe that the information described above is incorrect or incomplete for the following reasons:

_____

_____

_____

I hereby request that you amend the health information identified above as follows (Please write exactly what you think the entry should state to be accurate and complete):

_____

_____

_____

Additionally, I request that the following people be notified of the correction:
Name:_____

Address: _____City: _____State: ____Zip:_____

Name:_____

Address: _____City: _____State: ____Zip:_____

I understand that I will receive a copy of this Form and that my request will be processed within 60 days or I will be informed of the need for an extension of not more than 30 days to process the request. I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement disagreeing with the denial which must be contained on not more than one handwritten or typewritten page of at least 10-font. All information relative to my request for amendment will be linked to my records and disclosed to anyone for whom I authorize disclosure of information relative to the amendment.

_____	_____	_____	_____
Signature of Patient	or Parent/Legal Guardian/Authorized Person	Relationship to Patient	Date

We will **not** make the requested changes if:
(1) they involve records that you do not have the right to access; or
(2) we did not create the information (unless the person or entity that created the information is unable to act on your request); or
(3) the information is already accurate and complete.
If we agree to change your information, we will communicate the changed information to the persons or entities that you have designated. We will also communicate the changed information to any other persons or entities that we know have received the information before it was amended. If we are not able to act on this request in 60 days, we will notify you of the reasons for the delay.

FOR OFFICE USE ONLY

DATE RECEIEVED: AMENDMENT: □ Accepted □ Denied

If denied, reason for denial is:
□ Information was not created by this organization
□ Information is not a part of the patient's designated record set
□ Information is not available to the patient for access as required by federal law
□ Information is complete and accurate
□ Other _____

Comments of healthcare practitioner:
_____
_____
_____
_____

_____ _____ _____
Signature of Practitioner Title Date