Request for Amendment of the Medical Record

Patient name _____ DOB: _____

Address _____

_____ *Phone number:* _____
(City) *(State)* *(Zip)*

I feel the entry in my medical record made by (name) _____ on (date) _____ is not correct. The entry has errors about my condition / diagnosis / treatment.

I would like to add a statement to change the medical record. I understand that:

- My medical team may or may not agree to the amendment (correction).
- The hospital or clinic will add this amendment to my medical record.

Please explain how the entry is wrong or incomplete. What should the entry say?

_____

_____

_____

_____

_____

Would you like this correction sent to anyone that we may have given this information to in the past? If so, give the name and address of the organization or person.

Name: _____

Address: _____

Your request may take up to 60 days to process.

_____ _____/_____
Signature (Patient or Legal Representative) *Date* *Time*

Fairview patients, send to: **University of Minnesota Medical Center, West Bank**
Attn: ROI/Amendment Process
2450 Riverside Ave., West Building, F-108
Minneapolis, MN 55454

HealthEast patients, send to **HealthEast Release of Information**
Attn: ROI/Amendment Process
University Park Medical Building, Suite 180
1690 University Ave. W.
St. Paul, MN 55104

Request for Amendment of the Medical Record

Fairview/HealthEast internal use only:

Phone number of HIMS: _____

Date amendment received: _____

Patient name and MRN: _____

Date of request: _____

Healthcare provider name and clinic: _____

HIMS/Healthcare provider response:

I've reviewed the request and my response is

_____ Full acceptance

_____ Partial acceptance

_____ Full denial

_____ **(please circle)** In response to the patient's request, **a partial / full** correction / addendum will be made part of their permanent medical record.

_____ **(please circle)** The patient's request has been made a part of their permanent medical record; however, their request has been **partially / fully** denied for the following reasons:

___ The information was not created by this organization.

___ Federal law does not permit you to inspect the information (for example, psychotherapy notes).

___ The information is not part of your record.

___ The information is accurate and complete.

If the amendment is accepted partially, which part was denied? If it was denied fully, why was it denied?

_____

_____

_____

_____

_____ _____ _____

Healthcare Provider Signature *Date* *Time*