Memorial Healthcare

Request for Amendment to Protected Health Information

Patient Name: _____ Date of Birth: _____

Medical Record #: _____ Account#: _____

Patient Address:

_____

Date of Entry to be Amended: _____

Please explain how the entry is incomplete or inaccurate: _____

_____

_____

_____

Please explain what the entry should say to be accurate and complete: _____

_____

_____

_____

_____ _____

Patient Name (Please Print) **Date**

_____ _____

Signature of Patient or Legal Representative **Date**

****

****Submit form to:**

Director of Health Information Management/ Memorial Healthcare/ 826 W. King St. / Owosso, MI 48867

****

FOR HOSPITAL USE ONLY

Date Received: _____

Amendment Status: ❒ Accepted ❒ Denied

If denied, check reason for denial:

- ❒ Documentation specified was not created by our organization
- ❒ Documentation specified is not part of patient's Designated Record Set
- ❒ Documentation specified is accurate and complete
- ❒ Other

Comment of Healthcare Practitioner: _____

_____

Name: _____ Title: _____

Signature: _____ Date: _____

Scan this form in the correspondence section of the Medical Record when complete