RIVERSIDE

Clear Form

Save

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ **Birth Date:** _____

Patient Account Number: _____ **Medical Record Number:** _____

Patient Address: _____

Date of entry to be amended: _____ **Type of entry to be amended:** _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

_____

I authorize release of the amended information described herein to the following parties:

_____ _____

Name Address

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship of Legal Representative

For Healthcare Organization Use Only:

Date Received_____ Amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ PHI was not created by this organization
☐ PHI is not available to the patient for inspection as required by federal law (e.g. psychotherapy notes)
☐ PHI is not part of patient's designated record set
☐ PHI is accurate and complete

Comments of Healthcare Practitioner:

_____

_____

_____

_____

Name of Medical Records Custodian (printed)

_____ _____

Signature of Medical Records of Custodian Date and Time