

# Request for Correction/Amendment of Medical Record

Patient name: \_\_\_\_\_ Patient Birth Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street City State Zip code

Patient account #: \_\_\_\_\_

MHS affiliate: \_\_\_\_\_

Date(s) of entry in question: \_\_\_\_\_

Explain how the information is incorrect or incomplete. Include supporting information to assist in determining if the record should be amended.

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Please indicate if you need this amendment sent to anyone whom we may have disclosed the information to in the past. Please provide their name and address:

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\_\_\_\_\_  
Signature of patient/legal representative

\_\_\_\_\_  
Date

### For office use only:

Date amendment request received: \_\_\_\_\_ Referred to: \_\_\_\_\_

Accepted \_\_\_\_\_ Denied \_\_\_\_\_ (check reason below)

- PHI was not created by this organization
- PHI is not available to the patient for inspection (i.e. psychotherapy notes)
- PHI is not part of the patient's health record
- PHI is accurate and complete

Comments of physician:

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Patient notified of acceptance/denial on: \_\_\_\_\_ by: \_\_\_\_\_

Amendment accepted and record amended on: \_\_\_\_\_ by: \_\_\_\_\_

Amendment sent to those indicated above on: \_\_\_\_\_ by: \_\_\_\_\_

## Denial of Request for Correction/Amendment of Medical Record:

MHS Affiliate: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please be advised that your recent request for amendment to the information contained in your medical record has been denied for the following reason:

- MHS or an MHS affiliate did not create the information.
- The information is contained in records to which patient access is restricted.
- The information is not part of your designated record set.
- The information has been reviewed and found to be complete and accurate by the creator of the information or other designated reviewer.

As provided in section 164.526(d) of the HIPAA Privacy Regulations, you have the following rights and options:

- ♦ To submit a written statement disagreeing with the denial to the contact person below. The statement must be limited to 100 words or less. Upon review of the statement we may amend or deny your request. The results of the review will be sent to you.
- ♦ If you choose not to submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of the information in question.

Sincerely,

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Please indicate how you wish to proceed by checking the appropriate box and returning this form to the appropriate MHS affiliate Privacy Officer.

- I desire to submit a statement of disagreement with the denial. I want this statement included as part of my legal medical record. (This statement must be made in writing).
- I do not wish to submit a written statement disagreeing with the denial of my request. However, I request that MHS provide a copy of my Request for Amendment and the denial with any future disclosures of my personal health information that is subject to this amendment.
- I wish to make a formal complaint to Methodist Health System. I will submit it in writing to the Privacy Officer who is designated to receive and process my complaint.
- I wish to make a formal complaint to the Secretary of the Department of Health and Human Services. I request that MHS provide me with the information I require to proceed with this complaint.

Patient/Legal Representative: \_\_\_\_\_