

HEALTH RECORD CORRECTION/AMENDMENT FORM

Patient Name: \_\_\_\_\_ Patient Birth Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Date of Entry to be amended: \_\_\_\_\_

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name and address of the individual or organization.

Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative Date \_\_\_\_\_

**FOR [ORGANIZATION’S] USE ONLY:**

Date Amendment Request received: \_\_\_\_\_ Amendment Status: \_\_\_ Accepted \_\_\_ Denied

If Amendment Request is denied, check reason for denial:

- \_\_\_\_\_ The Protected Health Information was not created by this organization
- \_\_\_\_\_ The Protected Health Information is not available to the patient for inspection as required by law (e.g., psychotherapy notes)
- \_\_\_\_\_ The Protected Health Information is not part of the patient’s health record
- \_\_\_\_\_ The Protected Health Information is accurate and complete

Name of Staff Member: \_\_\_\_\_ Title: \_\_\_\_\_

Comments of Healthcare Practitioner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Healthcare Practitioner Date \_\_\_\_\_

*This document and the information contained therein are intended for illustrative purposes only. No information contained within this document constitutes legal advice and should not be relied upon as a substitute for legal advice or business advice or consulting services.*