Patient Name:______________________________________________ DOB: ____________________

Address:__________________________________ City:_______________ State:_____ ZIP: __________

Home Phone: (_______)______________________ Work Phone: (_______) ______________________

Medical Record Number:___________________ E-mail:______________________________________

Upon review of my medical information, I am requesting that Health Information Management (aka: Medical Records) review my record from service date:_____________ and consider amending the record as noted below. I understand that my request may not be granted. **I further understand that per Parkview retention policy, the original document cannot be altered or deleted unless the entry date is 30 years or older. Any change requested on an earlier dated entry will be made in the form of an addendum.** I also understand that this form will become a permanent part of my medical record, whether or not the request is granted, and that I have the right to submit a Statement of Disagreement should my request be denied. I understand that HIM must act on my request for an amendment no later than 60 days after receipt of my request.

**I request that the following information be corrected in my medical record:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**If this request is granted, I request a copy of this completed form be sent to:**

Name of Organization:_____________________________________ Fax: (_______) ____________________

Address:__________________________________ City:_______________ State:_____ ZIP: __________

Patient or Legal Representative Signature:________________________________________________

Relationship to Patient: ______________________________ Date:__________ Time:___________

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**PARTY RESPONSIBLE FOR RESPONSE:** ❑ Clinical Provider ❑ HIM ❑ Legal Department ❑ __________

❑ In response to your request, an addendum has been made to your permanent medical record.

❑ Upon review of your record, your request for amendment is denied for the following reason:_______________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Responding Party Signature:________________________________ Date:__________ Time:___________

HIM Professional Signature: ________________________________ Date:__________ Time:___________

*All entries must be dated and timed.*

- ❑ Parkview Regional Medical Center
- ❑ Parkview Hospital Randallia
- ❑ Parkview Huntington Hospital
- ❑ Parkview LaGrange Hospital
- ❑ Parkview Noble Hospital
- ❑ Parkview Ortho Hospital
- ❑ Parkview Wabash Hospital
- ❑ Parkview Whitley Hospital
- ❑ Parkview Physicians Group

# REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Ⓐ MR (Form #1211) (3-18)

PTAMEND