

Request for Amendment of Health Information

Member Identification

Member Name: _____ Date of Birth: _____ Member ID #: _____
Member Address: _____
Street Apt # City State Zip
Member Home Phone #: (____) _____
Member Wk. Phone #: (____) _____

Request for Amendment

[] Correction [] Addition Date of Entry to be Amended: _____
After review of my health information, I feel that the original documentation regarding

is inaccurate because _____
Therefore, I am hereby requesting that the following amendment be made to my health information and
become an approved attachment to my permanent record.

I understand this request applies only to the health information created by this company and that in order to
amend my health information created by another health care provider I must send a separate request to that
provider.
_____ Signature _____ Authority (If Personal Representative) _____ Date _____

This Section for Company Use Only

[] Request APPROVED

- Company Requirements; [] Attach amendment to all appropriate records
[] Notify Client of approval
[] Notify persons/agencies identified and authorized by Client

[] Request DENIED

- Reason for Denial: [] Information was not created by this company
[] Information was not part of a designated record set
[] Information is accurate and complete
[] Information is not available to Client per federal law

- Company Requirements: [] Provide written denial notice to Client
[] Inform Client of right to submit Statement of Disagreement

By: _____ Staff Signature _____ Title _____ Date _____