

## Amendment/Correction of Health Information Request

Patient name	Request date
Street address	Birthdate
City/state/ZIP	MHN/account no.

### WHAT NEEDS TO BE AMENDED/CORRECTED AND WHY

Entry to be amended \_\_\_\_\_

Date of entry \_\_\_\_\_ Author of entry \_\_\_\_\_

Explain how your health information is incorrect or incomplete. What should your health information state to be more accurate or complete.

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Would you like this information sent to anyone to whom we may have disclosed this information in the past:

Yes  No

If yes, specify the name and address of the organization or individual:

Name \_\_\_\_\_

Address \_\_\_\_\_

I understand that Marshfield Clinic may or may not amend my medical record with an amendment based on my request. This request for an amendment will be made part of my permanent medical record.

Signature of patient or patient's legal representative	Relationship	Date	Phone no.
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#### FOR MARSHFIELD CLINIC INTERNAL USE ONLY

Date received \_\_\_\_\_

Accepted  Denied

If denied, check reason for denial:

- PHI was not created by Marshfield Clinic
- PHI is not part of patient's designated record set
- PHI is accurate and complete
- Other (specify) \_\_\_\_\_

Comments:

Individual was informed of denial in writing (attach letter of communication)

Signature/title of staff member

Date