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|--------------|-----|-----|--------|
| Patient name | | | |
| MHN | DOB | Age | Gender |

Amendment/Correction of Health Information

Release of Information Request

| | | |
|-----------------|-------|--------------------------------------|
| Patient address | | Request date (month/day/year) / / |
| City | State | ZIP code |

WHAT NEEDS TO BE AMENDED/CORRECTED AND WHY

Entry to be amended _____

Date of entry (month/day/year) ____/____/____ Author of entry _____

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

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 Health System 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.

Patient signature (Patient's legal representative) (Relationship to patient) Signature date (m/d/y) Phone number

Minor patient signature (if applicable) Signature date (m/d/y) ____/____/____

Send completed request to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY

Date received (m/d/y) ____/____/____

Accepted Denied

If denied, check reason for denial:

PHI was not created by Marshfield Clinic Health System

Other (specify) _____

PHI is not part of patient's designated record set

PHI is accurate and complete

Comments:

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

Signature/Title of staff member Date (month/day/year) ____/____/____