MARSHFIELD CLINIC/FAMILY HEALTH CENTER

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 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 Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

FOR MARSHFIELD CLINIC INTERNAL USE ONLY

Date received (month/day/year) _____ /_____ /_____

☐ 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 (month/day/year)

  White: Medical record Yellow: Patient