Oneida Health

Request for Correction / Amendment of Health Information

Challenge to Accuracy

Patient's Name: _____ Date of Birth: _____

Patient's Account /MR# _____ Phone # _____

Patient Address: _____

After review of my medical record, I do not feel that the original documentation made by _____ on the date of _____ is accurate and should be supplemented with clarifying information. I understand the physician/clinician may or may not supplement the medical record with an addendum based on my request, and under no circumstances, is able to alter the original documentation. In any event, this request for an amendment will be made part of my permanent medical record and will be disclosed as part of the medical record in response to any authorized request for my medical information in the future.

I request the following correction / amendment be made to my medical record:_____

_____

_____

_____ _____

Signature (Patient or legal rep) **Date** **Time**

Would you like this amendment sent to anyone to whom we may have disclosed the information to in the past? If so, please specify the name and address of the organization or individual.

_____ _____

Name **Address**

INTERNAL USE ONLY:

Date received: _____ Amendment has been: ☐ Accepted ☐ Denied

If denied, check the reason for denial:

☐ PHI was not created by OHC ☐ PHI is not part of record set ☐ Other

☐ PHI not available to inspect ☐ PHI is accurate and complete

☐ In response to your request, a correction/amendment will be made as part of your permanent medical record.

☐ Your request has been made a part of your permanent medical record; however, your request has been denied- see above.

_____ _____

Provider's Signature Date

_____ _____

HIM Department Signature Date

cc: Patient, Medical Record, Physician

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