

Request for Amendment of the Medical Record

Client Legal Name			Name Client Would Like Used	
Address			Date of Birth	MRN
City	State	ZIP Code	Phone Number	Alternate Phone Number

After review of my medical record, I do not feel the original documentation made by _____
accurately reflects my information, condition, diagnosis and treatment on the following date(s) of service:

_____ and should be supplementing with clarifying information in the form of the addendum to the medical record.

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 of the medical record. In any event, this request of an addendum will be made part of my permanent medical record and will be sent as a part of the medical record in response to any authorized request for my medical information.

I REQUEST THAT THE FOLLOWING CORRECTION/SUPPLEMENTATION BE MADE ON MY MEDICAL RECORD:

I WOULD LIKE THE ADDENDUM SENT TO:

Name	Address	
City	State	ZIP Code

Signature of Client/Legal Guardian

Date of Signature

Relationship to Client

PHYSICIAN/CLINICIAN RESPONSE

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

Your request has been made a part of your permanent record; however, your request has been denied for the following reason:

The information you would like to have amended is not part of the designated record set.

The information you would like to have amended was not created by Preferred Family Healthcare. You may wish to ask the person or organization that created the information for an amendment.

The information you requested cannot be amended because you are not entitled to inspect this information.

The information is accurate and complete.

Signature of Physician/Clinician

Date of Signature