Request for Amendment of Health Information

Patient Name: _____Date of Birth: _____Record # _____

Address _____ City/State/Zip _____

1. Date(s) of information/entry to be amended (e.g. date of visit or call) _____
2. Describe the information/entry you want amended (e.g. nursing notes) _____
3. Please explain how the information/entry is incorrect or incomplete_____

_____

_____

4. What should the information/entry say to be more accurate or complete?_____

_____

5. Do you know of anyone who may have received or relied on the information/entry in question (such as your doctor, pharmacist or other health care provider? ☐ Yes ☐ No. If yes, please specify the name(s) and addresses(s) of the entity or individual:

_____

I understand that GCRMC may or may not supplement the medical record with an addendum based on my request. I also understand that GCRMC is not able to alter the original documentation of the medical record. If the requested addendum is made part of my permanent medical record, GCRMC will make reasonable efforts to inform and provide the addendum within a reasonable time to the entity or individual identified above as having relied on the content of my medical record.

Signature of Patient or Personal Representative: _____ Date: _____
(If Personal Representative, include a description of authority to act for patient)

Return this completed form to GCRMC's HIPAA Privacy Officer.
If you have any questions, please call 575-443-7857

For GCRMC Use Only:

Amendment has been: ☐ Accepted ☐ Denied

If denied, check the reason for denial:

☐ Health information was not created by GCRMC

☐ Health information is not part of the patient's designated record set

☐ Federal law forbids making the health information in question available to the patient for inspection

☐ Health information is accurate and complete

☐ Originator of the record is not available because _____

GCRMC Healthcare Practitioner comments _____

_____

_____

☐ Denial letter sent to individual **(The Privacy Officer Must Review All Denials)**

Signature of GCRMC Healthcare Practitioner _____ Date _____

Print Name & Title_____

Gerald Champion Regional Medical Center
The Evolution of Excellence