

**REQUEST FOR AMENDMENT OF HEALTH INFORMATION**

Submit completed (signed and dated) form to Medical Records at 18697 Bagley Road, Middleburg Heights, OH 44130

**Patient Information**

Name (First, M.I., Last):	Date of Birth:
Current Address:	City State Zip
Email:	Phone Number: ( )

**1. Description of information requested to be changed (amended):**

Date of Service	Information Type (lab test, ER Visit, Progress Note, etc)	Provider/Clinician Name

**2. Where did you observe the information requested for amendment?**

- 
- Medical Record document
- 
- HealtheLife Patient Portal
- 
- Other: \_\_\_\_\_

To help with processing your request, please include a copy of the information requested to be changed.

**3. What is the reason for making this amendment request:** \_\_\_\_\_

**4. What does the current information say that you believe to be inaccurate?**


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**5. What change to the documentation do you believe would improve the accuracy of the information?**


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**6. If your request is approved, is there anyone you would like us to notify who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?**

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- Yes
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- No

**7. If yes, please specify the name(s) and address(es) of the organization(s) or individual(s):**


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 Signature of patient or legal representative  \_\_\_\_\_ Date \_\_\_\_\_

*If other than the patient's signature, a legal representative is a court appointed guardian, durable power of attorney for health care, or parent signing for a patient under the age of eighteen..*
**FOR HEALTHCARE ORGANIZATION USE ONLY**

 MRN / FIN: \_\_\_\_\_ Amendment has been:  Accepted  Denied

**If denied, check the reason for denial:**

- 
- Protected Health Information (PHI) was not created by this organization
- 
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- PHI is not part of the Southwest General's designated record set
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- Federal law forbids making the PHI in question available to the patient for inspection (e.g., psychotherapy notes)
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- PHI is accurate and complete as of the time it was written

 \_\_\_\_\_  
 Signature of Authorized Person

 \_\_\_\_\_  
 Date

Staff Comments: \_\_\_\_\_

