DENVER HEALTH MEDICAL CENTER

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Patient Name: _____ DOB: _____

Medical Record Number: _____

Address: _____

Phone Number: _____

After review of my medical record, I do not feel the original documentation made by:

_____

_____ (Care Provider/s)

accurately reflects my condition/diagnosis/treatment on the following service date(s): _____

_____

and should be supplemented with clarifying information in the form of an addendum to the medical record.

I understand that the physician or other care provider may or may not supplement the medical record with an addendum based on my request. I also understand the addendum request will be made part of my permanent medical record. If the amendment is denied, I can submit a written request to have all future disclosures of my medical information include the denial letter and a statement of disagreement. That request must be received by the HIM department within 30 days of the denial.

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

_____

_____

_____

_____

_____

_____ _____

Signature (Patient or Legal Representative) Date

SECTION II – To be completed by provider

_____ The care provider agrees with the above amendment 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 medical record; however, your care provider disagrees with your amendment for the following reasons:

☐ Other: _____

_____

Care Provider Signature/Title Date (mm/dd/yy) Time (00:00) (Pager & Provider #)