AMENDMENT REQUEST FOR MEDICAL RECORD

(All areas must be completed)

Patient name: _____ Patient Date of Birth: _____

Patient Address: _____
Street City State Zip Code

Patient Account # _____ Date(s) of entry in question: _____

Provide your correction or additional information, and your reason for adding this information. Include supporting information to assist in determining if the record should be amended. (Use additional page if necessary)

_____

_____

_____

Please indicate if you need this amendment sent to anyone whom we may have disclosed the information to in the past. Please provide their name and address:

_____

_____

_____

_____

_____ _____
Signature of patient/legal representative Date

For office use only:

Date and Time amendment request received: _____ Referred to: _____

Accepted _____ Denied _____ (check reason below)

_____ PHI not created by this organization
_____ PHI is not available to the patient for inspection
_____ PHI is not part of the patient's health record
_____ PHI is accurate and compete

Author comments:

Patient notified of acceptance/denial on _____ by _____
Amendment accepted and record amended on _____ by _____
Amendment sent to those indicated above on _____ by _____

central peninsula hospital
250 Hospital Place, Soldotna, AK 99669
(907) 714-4404 * www.cpgh.org