2AMENDMENT

Date Requested: _____

Please read the following and complete the information requested

Patient Name:	**Date of Birth:**	**Medical Record Number (If known):**
Mailing Address:		**Phone Number:**

If you believe that the protected health information the Hospital has on file about you is incorrect or incomplete, you have the right to ask us to correct the information in your records.

Please specify the document(s) with incorrect or incomplete information:

Name of the Document (Operative Report, History & Physical, Progress Notes, etc.)	**Date of the Document**	**Author of the Document**

Please check one (1) box to indicate what type of change you would like to make to your personal health information:

☐ **Addendum** – you are requesting to include an additional statement into your medical record. Please provide your statement below in 250 words or less (you may attach additional sheets as necessary).

☐ **Amendment (Correction)** – you are requesting the authoring clinician to make changes to your personal health information. Please explain below what changes you would like made and why you want this change (a reason must be given)

_____

_____

_____

_____

_____

If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incorrect or incomplete. We must inform you within 60 days of receipt if we will change your protected health information as you requested, or inform you that we need more time (up to 30 additional days) to review your request.

JOHN MUIR HEALTH

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We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it.
2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want to change.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

If we decide to change the health information as you requested, please let us know if there is anyone else who you would like informed:

☐ Yes, Initial:_____ ☐ No, Initial:_____

If yes, please indicate who you would like to be informed

Name	**Address**

We will also send the amendment to other persons that we know received the information before it was changed if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

☐ Yes, Initial:_____ ☐ No, Initial:_____

_____ _____ _____ _____

DATE TIME SIGNATURE (Patient, or Properly Designated Representative) INITIALS

_____ _____

PRINT NAME RELATIONSHIP TO PATIENT

Please send this request to the address at the bottom of this form.

For more information about your privacy rights, see the “Notice of Privacy Practices” available on our website at www.johnmuirhealth.com or by sending a written request to the address at the bottom of this form.

John Muir Health, Health Information Management Services
5003 Commercial Circle, Concord, CA 94520 Phone: (925) 947-5373 Fax: (925) 674-2321

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AMENDMENT REQUEST

PATIENT LABEL