**Request for Amendment to the Medical Record Form**

You have the right to request an amendment to your Conway Regional Health System (CRHS) medical record if you believe the information is incorrect or incomplete.

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach a detailed explanation that describes what you believe to be incorrect or incomplete. Include dates of involved notes or test results and the wording you would like your medical record to reflect.

I understand that this amendment request will become a part of my legal medical record. I understand that I will receive a response to my above request within 60 days or I will receive a request for an additional 30-day extension.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Date:

**Determination:**

\_\_\_\_\_ Request Accepted \_\_\_\_\_\_ Request Denied

Denied: Your requested amendment has been denied for the following reason:

\_\_\_\_\_ The information was found to be accurate and complete

\_\_\_\_\_ The information was not created by CRHS and you should contact the originator

\_\_\_\_\_ The information is not part of the designated record set at CRHS

\_\_\_\_\_ Federal law does not permit you to inspect the information (§164.524)

Additional Information, if any:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your Request is Denied:

You have the right to submit a written statement describing why you disagree with the denial decision. The statement should be specific to the medical record documentation and should not include other issues or concerns. It will become part of your legal medical record.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services @ <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html> or mail your complaint to Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509 F, HHH Bldg. Washington, DC 20201.

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Signature, Title Date