Patient Name:_____ DOB:_____

Address:_____ City:_____ State:_____ ZIP:_____

Home Phone: (_____)_____ Work Phone: (_____) _____

Medical Record Number:_____ E-mail:_____

Upon review of my medical information, I am requesting that Health Information Management (aka: Medical Records) review my record from service date:_____ and consider amending the record as noted below. I understand that my request may not be granted. **I further understand that per Parkview retention policy, the original document cannot be altered or deleted unless the entry date is 30 years or older. Any change requested on an earlier dated entry will be made in the form of an addendum.** I also understand that this form will become a permanent part of my medical record, whether or not the request is granted, and that I have the right to submit a Statement of Disagreement should my request be denied. I understand that HIM must act on my request for an amendment no later than 60 days after receipt of my request.

I request that the following information be corrected in my medical record:

_____

_____

_____

_____

_____

If this request is granted, I request a copy of this completed form be sent to:

Name of Organization:_____ Fax: (_____) _____

Address:_____ City:_____ State:_____ ZIP:_____

Patient or Legal Representative Signature: _____

Relationship to Patient: _____ Date:_____ Time:_____

PARTY RESPONSIBLE FOR RESPONSE: ❑Clinical Provider ❑HIM ❑Legal Department ❑_____

❑In response to your request, an addendum has been made to your permanent medical record.

❑Upon review of your record, your request for amendment is denied for the following reason:_____

_____

_____

_____

Responding Party Signature:_____ Date:_____ Time:_____

HIM Professional Signature: _____ Date:_____ Time:_____

✦ PARKVIEW
HEALTH
❑ Parkview Regional Medical Center
❑ Parkview Hospital Randallia
❑ Parkview Huntington Hospital
❑ Parkview LaGrange Hospital
❑ Parkview Noble Hospital
❑ Parkview Ortho Hospital
❑ Parkview Wabash Hospital
❑ Parkview Whitley Hospital
❑ Parkview Physicians Group

All entries must be dated and timed.

**REQUEST FOR
AMENDMENT
OF HEALTH
INFORMATION**

Ⓐ MR (Form #1211) (3-18)

PTAMEND