gillette CHILDREN'S

Request For Amendment Of Protected Health Information

Send to: Gillette Children's Specialty Healthcare 200 E. University Ave. Mail Code -10604 St. Paul, MN 55101
Attn: HIM

PATIENT FULL LEGAL NAME:_____ **DATE:** _____

MEDICAL RECORD: _____ **D.O.B.** _____

PATIENT ADDRESS: _____ **PHONE: (H)**_____

PERSON MAKING REQUEST: _____ **(W)**_____

After review of my protected health information, I do not feel the original documentation made by _____ 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 the physician may or may not supplement the medical record with an addendum based on my request, and under no circumstances, is able to alter the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

Please explain how the entry is incorrect, incomplete or outdated? _____

_____

_____

What should the entry say to be more accurate or complete? _____

_____

_____

Do you know of any person/organization who may have received or relied on the information in question? If so, please include name and address: _____

Signature of patient or legal representative: _____ **Date:** _____

FOR HEALTHCARE ORGANIZATION USE ONLY

Amendment has been: ____ Accepted ____ Denied ____ Partial Acceptance

If denied, check reason for denial:

- ☐ PHI was not created by this organization
- ☐ PHI is not part of patient's designated record set
- ☐ PHI is not available to the patient for inspection, as required by federal law (e.g. psychotherapy notes)
- ☐ PHI is accurate and complete

Signature of Privacy Officer: _____

Date _____ Time: _____

- ☐ Patient has not filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.
- ☐ Patient has filed a Statement of Disagreement that must be released along with other documentation with any future releases of information.
- ☐ Facility/provider appended written response (rebuttal) and forwarded to patient.
- ☐ Facility/provider did not provide a response/rebuttal.

Staff Signature: _____**DATE**_____**TIME**_____

Name (Print)/Title: _____

8083-023
6/04, 10/07, 5/09, 6/13, 10/14, 7/18