



**REQUEST FOR AMENDMENT OF HEALTH INFORMATION**

*Please fill in the following information:*

Today's date \_\_\_\_\_

Patient's name \_\_\_\_\_

Birthdate \_\_\_\_\_ Patient medical record # \_\_\_\_\_

Patient Address \_\_\_\_\_

Phone Number (H) \_\_\_\_\_ (W) \_\_\_\_\_

**I understand the health care provider may or may not supplement the medical record with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical record. This request for an addendum may be made part of my permanent medical record and will be sent to individuals/organizations identified below as having relied on the content of my medical record.**

Describe the information you want amended (e.g., lab test results, physician notes) \_\_\_\_\_

What would you like to add/ change to the record? \_\_\_\_\_

Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care service) \_\_\_\_\_

What is your reason for making this request? \_\_\_\_\_

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other health care provider)?  yes  no

If yes, please specify the name(s) and address (es) of the organization(s) or individual(s). \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Do you want this Request for Amendment, and the amendment or denial of amendment to be included in your medical record?  Yes  No**

(See page 2)





**EXETER HOSPITAL**

5 Alumni Drive Exeter, NH 03833 603.778.7311

**FOR HEALTH CARE ORGANIZATION USE ONLY**

Amendment has been:  Accepted  Denied

If denied, check the reason for denial:

- Health information was not created by this organization
- Health Information is not part of the patient's health record
- Federal law forbids making the health information in question available to the patient for inspection (e.g., psychotherapy notes)
- Health Information is accurate and complete
- Originator of the record is not available because \_\_\_\_\_

Staff comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The Information Security Officer Must review all Denials**

Signature of Privacy Officer \_\_\_\_\_

Denial letter sent to individual

Signature of staff person \_\_\_\_\_ Date \_\_\_\_\_

Print Name & Title \_\_\_\_\_

When this Form is completed, send/ provide a copy of this document to the patient

