

## Request for Health Record Amendment or Correction

**Section 1 Patient Information**

Patient Name: \_\_\_\_\_  
Last Name First Name M.I.

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Address: \_\_\_\_\_  
Street City State Zip

**Section 2 Amendment Information**

Date of entry to be amended: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Type of entry to be amended:  visit note  procedure note  other: \_\_\_\_\_

Date of correction or amendment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Explain how the entry is incorrect or incomplete. Please state what the entry should say to be more accurate or complete. (Attach additional pages as necessary)

If we refuse your request to make the correction or amendment you have the right to provide us a brief statement describing the correction or amendment you requested as well as the reasons for your request. The statement you provide will be added to your Rockwood health record.

Once we have your statement we will indicate in your health record the specific portion of your record that you believe is incorrect, incomplete or inaccurate. We will also add your statement to your health record.

Would you like the amendment or correction sent to anyone to whom we may have disclosed the information in the past? (check one)  Yes  No

Signature of patient/legal representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed name of patient or legal representative \_\_\_\_\_

Relationship to patient, if other than patient \_\_\_\_\_

Rockwood representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Health Information Management Use Only:**

**RWC MR#:** \_\_\_\_\_

Date Received: \_\_\_\_\_

Correction/Amendment has been:  Accepted  
 Denied

If denied, check reason for denial:

- PHI was not created by this organization
- PHI not part of the Designated Record Set
- Disagreement with Amendment or Correction

Comments of practitioner or RWC staff member:

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