Request for Amendment of Health Information

Date _____

Patient Name _____ Date of Birth _____

Medical Record Number _____ Social Security # _____

Phone Number _____

Address _____ , _____

Please complete the following section and attach any additional writing on a separate sheet of paper.

1. What is the information that you want amended? (e.g. lab test results)

_____

_____

2. What is the date of the medical record entry or date of service for the information to be amended?

_____

_____

3. Where in the medical record is the information recorded? (e.g. nurses notes, physician notes, operative report, etc.)

_____

_____

4. Why are you requesting the amendment?

_____

_____

5. How is the information inaccurate, incomplete, or outdated?

_____

_____

_____

6. Please state how the amendment should appear within your medical record.

_____

_____

7. Please specify the name(s) and address(es) of any persons or organizations that you want informed of the amendment. By submitting these names, you agree that we may notify them of the amendment, if it is accepted.

_____

_____

_____

_____

Signature of Patient or Legal Representative Date

If you have any questions regarding completion of this form, please contact:

Jennifer Manahan, RHIA
Via Christi Clinic, P.A.
Manager, Health Information Management
(316) 689 −9530

For Via Christi Health Ministry use only:

Received by _____

Title/Department _____

Date of Receipt _____