MRN: _____

CSN: _____

Anne Arundel Medical Center
Annapolis, MD 21401

Request for Amendment of the Medical Record

(Please see the instructions on the reverse side of the yellow copy of this form)

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

The reason for this request is I believe the information contained in my medical record is:

❑ incorrect ❑ incomplete ❑ other _____

_____

_____

I identified this information by: ❑ reviewing MyChart ❑ obtaining a copy of my medical record

The record to be amended is *(please provide specific details relating to the information - attach a copy of the record if possible):*

Date of Service: _____ Document Type: _____

[ie: History, Radiology report, operative report, problem list, etc.]

Documented by: _____

[name of provider and clinic or department]

I would like to request the following changes to my medical record *[please be specific]*: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby authorize AAHS to mail this Request for Addendum and the Addendum / Denial Statement to:

Recipient Address

1. _____
2. _____
3. _____

I have read the instructions on the back of the patient's copy of this form. I understand the provider may or may not agree to supplement my medical record with an addendum based on this request, and UNDER NO CIRCUMSTANCES, is able to alter the original documentation in accordance with federal and state law. I understand that any requests for information regarding this service date will be accompanied with the request for addendum and the addendum / denial (as applicable).

Signature *(Patient or Legal Representative)* _____ Date: _____

Relationship to Patient _____

FOR OFFICE USE ONLY -

Date Received: _____ Received by: _____

❑ Request to Amend Accepted Date Approval letter mailed: _____ Date Extension letter mailed: _____

❑ Request to Amend Denied Date Denial letter mailed: _____ Disagreement Received: _____

Authorized Individual: _____ Signature: _____ Date: _____ Pages Scanned: ____

85144

WHITE - PRIVACY OFFICE
YELLOW - PATIENT COPY

REV. 8/28/13

Request for Amendment of the Medical Record

As a patient at Anne Arundel Health System (AAHS), if you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health System. To make a correction to your medical record a request must be submitted in writing (on this form) to the Health System's Privacy Officer. Once received, each request is processed as quickly as possible; however, we are allowed 60 days to complete the request. If during this time we feel we are unable to meet this timeline, we are allowed by law one 30-day extension. Should an extension be needed you will be contacted in writing with the reason for the delay.

Your request and medical record will be carefully reviewed. **UNDER NO CIRCUMSTANCES MAY DOCUMENTATION BE EXPUNGED OR DELETED FROM THE MEDICAL RECORD.** If the request can be honored an amendment will be made and you will be notified in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us.
- The person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Health System;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If your request is denied, you have the right to submit a Statement of Disagreement which will be included in your medical record.

INSTRUCTIONS TO COMPLETE the **Request for Amendment of the Medical Record** form. Please complete the form in its entirety. If more space is needed, please use an additional sheet of paper.

- Complete the patient information section.
- Provide the reason you are requesting an amendment to the patient's medical record.
- Provide the name of the provider, date of service and document type where you see the information you want amended. If possible provide a copy of the document with your request to amend the medical record. If the information is located on your MyChart account, please provide details and if possible a screen shot/printed copy of the information.
- Provide the specific information you want to be included in the amended entry.
- Provide the names and addresses of anyone you want to receive a copy of your request to amend the medical record along with the amendment or denial.
- Sign and date the form. If you are acting on behalf of the patient, please include documentation giving you this authority (medical power of attorney, guardianship papers, etc.)

KEEP THE YELLOW PATIENT COPY OF THIS FORM FOR YOUR RECORDS