CONCORD HOSPITAL | Franklin

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concordhospital-franklin.org

AMENDMENT OF THE MEDICAL RECORD REQUEST

Name:_____ DOB:_____ Medical Record #:_____

Address: _____

Phone number: (Home) _____ (Work) _____

After review of my medical record, I do not feel the original documentation made by _____ _____ accurately reflects my condition/treatment/diagnosis/treatment of service and should be supplemented with explanatory information in the form of an addendum to the medical record. I understand the health care provider may or may not supplement the medical records with an addendum based on my request, and under no circumstances, is able to modify the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record. In addition, I understand that my request will be processed in 60 days or I will be informed of the need of an extension of not more than 30 days.

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

_____

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

_____

What is your reason for making this request?_____

_____

How is the entry incorrect, incomplete or outdated? _____

_____

_____

_____

_____

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

_____

_____

_____

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

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

Name:_____ Address:_____

Name:_____ Address:_____

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