North Star HEALTH

OFFICE USE ONLY: Patient Label Or Print Name/DOB

Patient Name:_____

DOB: _____/_____/_____ MR#_____

Account #_____

Request for Amendment to the Medical Record Form

Patient's Name _____ Date of Birth: ____/____/____

Patient's Address _____ Date of Service: _____/_____/_____

_____ Phone # _____

You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete. The amendment would include the information you believe is in error, and your proposed corrections to that information. To request an amendment to your medical information, please fill out this form in its entirety. You may mail, fax or deliver the form and any supporting documentation in person.

Type of Entry(ies) or Report(s) to be Amended:	Date(s) of Entry(ies) to be amended:

Please explain the information that you believe to be incorrect or incomplete. Include what you feel should be excluded/included in order to make the record more accurate or complete.

If this amendment request is approved, please specify the name(s) and address(s) of any organizations or individuals you would like us to send the amended information to.

I understand that this amendment request will become a part of my medical record. I understand that I will receive a response to my above request within 60 days or I will receive a request for an additional 30-day extension.

_____ _____/_____/_____

Signature of Patient Date

_____ _____ _____/_____/_____

Signature of Legal Representative Relationship to Patient Date

Health Information Management

Attention: Privacy Officer, 100 River Street, Springfield, VT 05156

Phone Number: (802)-692-7177 patientrelations@northstarfqhc.org

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Patient Name:_____

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Account #_____

Request for Amendment to the Medical Record Form

Practitioner Determination:

☐ Accepted: Your requested addendum will be made to your permanent medical record.

☐ Denied: Your requested amendment has been denied for the following reasons:

- ☐ The information was found to be accurate and complete
- ☐ The information you want changed was not created by Copley Hospital.
- ☐ Federal law does not permit you to inspect the information (for example, psychotherapy notes).
- ☐ The information is not part of your medical record at Copley Hospital.
- ☐ The information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding.

Reason for Practitioner/MD Denial: _____

_____

If your Request is Denied:

- You have the right to submit a written statement describing why you disagree with the above denial decision OR
- You may request in writing that North Star Health provides this request for amendment and the denial with any future disclosures of your protected health information.
- You also have the right to file a complaint with the Secretary of the Department of Health and Human Services at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or mail your complaint to Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509 F, HHH Bldg. Washington, DC 20201

_____ _____/_____/_____

Physician/Practitioner Signature Date

Patient Request Form was received on _____/_____/_____

Patient was informed of decision on _____/_____/_____ by ☐ Phone Call ☐ Letter Mailed:___/___/___

_____ _____/_____/_____ Signature of Privacy Officer

Date

_____ _____/_____/_____ Signature of Compliance

Officer Date

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