PATIENT REQUEST TO CORRECT/AMEND MEDICAL RECORD

First Name: ______________________ **Last Name:** _______________________ **Date of Birth:** ___________

Previous Name (if applicable): ___________________________

Please provide a brief description of which information in your medical record you believe needs to be corrected/amended and what you believe it should say instead:

Date(s) of Service: ___________________

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If you have any documentation to support your request, please send a copy along with this form.

Return the completed form to UCNW's Health Information Management Department:

Attn: HIM/Referrals Supervisor
1616 Cornwall Ave
Suite 115
Bellingham, WA 98225
Fax: (360) 671-3574

____ _________________
Patient or legally authorized individual signature **Date**

____ ______________________________
Printed name if signed on behalf of the patient **Relationship**

Patient Notices

In accordance with RCW 70.02.100, this request will be submitted for review to the provider who created the portion of the record you want amended. Your provider will decide whether the requested changes are appropriate. You will receive a response within ten days, including in situations where the provider needs more than ten days to make a decision.

Unity Care NW
Health Care for Everyone

For Administrative Use Only
Date Sent to Provider: _____________ Initials: ______
or
Request Denied:
___ Disputed information came from outside medical records
___ The records no longer exist. Destruction date: ___________
___ Other. Please specify:

Provider Instructions

1) Review the requested changes to determine if they are, according to your professional judgement, accurate and appropriate.
2) If you agree with the requested changes, create an append on the pertinent document (office note, chart note, etc.) and add the updated information. DO NOT delete documents from the chart.
3) Complete the Provider Response portion of this form and send completed form to HIM.

IMPORTANT: You are not obligated to make any changes requested by the patient. If you do not agree with the patient's statement, then you can deny the request.

If you require assistance, please contact the HIM/Referrals Supervisor or Support Services Manager.

Provider Response
Upon review of the above patient's medical record, the request to correct/amend has been:

___ Approved.

___ Denied. Reason:
    ___ Record is accurate as written
    ___ Other. Please specify:

____ _______________
Signature Date