

REQUEST FOR CORRECTION/AMENDMENT OF MEDICAL RECORD

Patient Name: _____ Date of birth: _____ MR# _____

Patient Address: _____

Date of entry to be amended: _____

Type of entry to be ☐ amended ☐ corrected : _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

Upon acceptance of this amendment, who else would you like us to supply this information?

Name	Address
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Signature of patient or legal representative	Date
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For Children's Hospitals and Clinics of MN use only:

Date Received: _____ Amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial:

- | | |
|--|--|
| ☐ PHI was not created by Children's
☐ PHI is not available to patient for inspection
as required by federal law (e.g. psychotherapy notes) | ☐ PHI is not part of patient's designated record set
☐ PHI is accurate and complete |
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Comments of Healthcare Practitioner:

Name of Staff member	Title
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Signature of Healthcare Practitioner	Date
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PLEASE FORWARD THIS IN A CONFIDENTIAL ENVELOPE TO HIM DIRECTOR, MAILSTOP B832

