REQUEST FOR AMENDMENT OF MEDICAL RECORDS

Please retain this top sheet for your personal records

To submit a request, please complete, sign and return the attached form along with a copy of the medical record page(s) to:

Health Information Management Department
NCH Business Center
1100 Immokalee Road, Suite 100
Naples, FL 34110
Phone: (239) 624-6577
Fax: (239) 624-6581

The attached form may be used to request an amendment to a record of your medical care. We are required to amend your medical record, upon request, unless (1) we did not create the information, (2) we do not maintain the information as part of your record, (3) we determine that the information is accurate and complete as currently recorded, or (4) the information is the type that would not be available to you for inspection. Please be aware, however, that under no circumstances will we delete or alter the original documentation in the medical record.

If we did not create the information that you want to have amended, you may submit reasonable evidence that the person or organization that originally created the information at issue is no longer available (i.e., evidence that the doctor who created the information has died, etc.), and we will consider your request.

We usually respond to requests for amendments within 60 days of receiving them. You may expect to receive a response or a notification of delay within that approximate period. If we deny your request to amend, you may submit a one page/word statement of rebuttal, which will be included in all subsequent disclosures of the information at issue. If you choose not to submit a statement, we will include a copy of this request for amendment in all subsequent disclosures of that information, upon receiving your written request to make that inclusion.

For more information about amending a medical record, you may contact our HIM Department, at (**239) 624-6577**. Note, however, that requests for amendment must be in writing and will not be accepted over the phone.

NCH Request for Amendment of Medical Records

Today's Date: _____

Patient Name: _____

Medical Record # (if known): _____ Birth Date: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Work or Cell: _____

Describe the information that you would like to have amended (e.g., physician notes, lab test results):

_____

_____

On what date(s) was the care that is described in the record provided?

_____

What is incorrect about the record? What would you like to change/add to the record?

_____

_____

_____

To your knowledge, has anyone received or relied on the information (i.e., your doctor, another health care provider, an insurance company)? If yes, please provide the **name(s)** and **address(es)** of those individuals or organizations so that we may inform them of any amendments.

_____

_____

Signature: _____ Date: _____

REQUEST FOR AMENDMENT OF MEDICAL RECORDS
COMPLIANCE AND PRIVACY / HEALTH INFORMATION MANAGEMENT
NCH HEALTHCARE SYSTEM

If you are not the patient, please fill in the following:

Name: _____

Relationship to the patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Work or Cell: _____