REQUEST FOR AMENDMENT TO PATIENT INFORMATION

Patient Label

DATE:

MRN:

NAME

Date of Birth:

You have the right to request corrections or amendments to Personal Health Information we retain on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request but each request will be carefully reviewed and corrections or amendments made if warranted. You will be notified when your request has been approved or denied.

☐ *Please check here if there are third parties that you would like us to notify about this amendment to your information. We will include a form for you to complete when we send you our response to this request.*

When completed, please return this form to: Henry Ford Health System, ATTN: Medical Records Department, 2799 W. Grand Blvd. K1, Detroit, MI 48202 or Fax: (313) 916-9186

REQUESTOR INFORMATION

If the requestor is the personal/legal representative, please attach certifying documentation of your status as the personal/legal representative, such as a Durable Medical Power of Attorney or Guardianship papers.

Patient: ______________________________ ____________ ____________
(Name of Patient) (Last 4 Digits of SSN#) (Date of Birth)

Requested by (if other than patient): ______________________________ ____________
(Personal /Legal Representative of Patient) (Relationship to Patient)

Patient/Requestor Contact Information: ______________________________ ____________
(Street Address) (City/State/Zip) (Telephone)

Patient/Requestor Signature: ______________________ **Date:** __________ Time__________

AMENDMENT REQUEST

Specify the records you wish to amend/correct:

☐Test results ☐Emergency Visit ☐Office Note ☐Diagnosis ☐Treatment information ☐Other __________

Please include dates of service and reason for amendment:

☐ Check here if you have attached additional information to this form.

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FOR HFHS USE ONLY

For HIM Use Only

Received By: __________ Date Received: __________ Date Forwarded to HIM: __________
(Initials)

Processed By: ______________________ ☐ Denied: __________ ☐ Accepted: __________

Date Response Letter Sent to Patient: __________ Date sent for scanning: __________

Comments: ____

Form #: HFH-50-3214MR-0118