Hennepin Healthcare

701 Park Ave S – S7
Minneapolis, MN 55415
612-873-3179 – phone
612-873-1516 – fax

Request for Amendment of the Medical Record

First Name	Middle Name	Last Name
Street Address		Date of Birth __ __ / __ __ / __ __ __ __ Month Date Year
City	State and Zip	Phone
Any previous names or aliases		MRN

Date of entry to amend: _____ Type of entry to amend: _____

Name of Health care provider: _____

Explain how the entry is inaccurate or incomplete. What should the entry say to be more accurate and complete?

_____

_____

_____

_____

_____

I understand that the health care provider may or may not supplement the medical record with an addendum based on my request. The health care provider, under no circumstances, is able to alter the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information if approved by provider or a statement of disagreement is submitted by me.

Signature – Required for the request to be processed:

_____ _____ _____

Patient/Legally Authorized Representative* **Relationship to the Patient** **Date Signed**

HEALTH CARE PROVIDER RESPONSE

_____*In response to your request, a correction/addendum will be made part of your permanent medical record.*

_____*Your request has been made part of your permanent medical record; however, your amendment has been denied for the following reasons* **(Must specify reasons):**

_____

_____

_____

Healthcare Provider Signature: _____ **Date:** _____

Healthcare Provider Printed Name: _____ **Date:** _____

OFFICE USE ONLY

Date Request Received: _____ ☐ Administratively Closed Date: _____

HCMC HIM Operations Manager Signature: _____ Date: _____