Hennepin Healthcare

Request for Amendment of the Medical Record

First Name	Middle Name	Last Name
Street Address		Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)
City	State and Zip	Phone
Email Address (if agreeing to email communications throughout the amendment process)		
Any previous names or aliases		MRN

Date(s) of visit(s) that needs to be corrected: _____

Type(s) of visit(s) that needs to be corrected: _____

Name of healthcare provider (please submit a separate form for each provider involved): _____

Explain how the entry or information is inaccurate or incomplete. What should it 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 healthcare 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 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: _____

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