Hennepin Healthcare

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
Email Address (if agreeing to email communications throughout the amendment process)		
Any previous names or aliases		MRN (if known)

Information or Documentation to be corrected: _____

Date of Service/Date of Entry to be corrected: _____

Name of Health Care Provider/Author: _____

(please submit a separate form for each provider involved)

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

_____

_____

_____

_____

If this amendment is accepted, would you like this amendment sent to anyone to whom we may have shared this information in the past? If so, please specify the names & addresses, fax, or secure email of the individual or organizations:

_____

_____

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 document 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 the provider or a statement of disagreement is submitted by me.

Signature of Patient: _____ Date: _____

Legal Representative's Signature: _____ Date: _____

(If patient is unable to sign)

Relationship to Patient: _____

HIM Operations Department
701 Park Avenue – S7
Minneapolis, MN 55415

Phone: 612-873-3179
Fax: 612-904-4332
Email: HIMOperations@hcmed.org

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