REQUEST FOR AMENDMENT IN MEDICAL RECORD

Patient Name: ____ Date of Request: ____________

Address: ____

Date of Birth: __________________________ Contact telephone number: __________________________

This section to be completed by the patient. Additional pages may be attached if more space is needed.

I request the following information to be amended in my medical record:
Date(s) of entry to be amended:

____

Description of information to be amended:

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Reason for Request:

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If possible, please enclose with this request copies of the specific information to be amended.

If your request is approved, we can provide copies to persons who received your protected health information who need to see the amendment. Please include name, title and mailing address for each:

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<u>If your request is denied:</u>

- You may submit a statement disagreeing with the denial.
- You may request your original amendment request and/or your disagreement with the denial be attached to future disclosures of your protected health information
- You may file a complaint with the practice or the U.S. Department of Health and Human Services.

MFM | HEALTH

I acknowledge by signing this form in the section below I consent to and agree MFM Health may receive and process this amendment request as it applies to all records stored within our electronic medical record system. Additionally, I understand the practice has 60 days to respond to the amendment request from the date of receipt of this completed form. If the practice is unable to act on the request within 60 days, an extension of 30 days may be required. If an extension is required, notification will be provided along with a written explanation.

Patient/Guardian signature: ____
Date: ____________________________

If Guardian, please print name: ____

Guardian relationship: ____

Please return completed form to:
MFM Health
Chart Correction Unit
Mail: 147 S. Main Street
Middleton, MA 01949
Fax: 978-774-8715

If you have questions about this process, please call the practice at 978-774-2555.