



* 0 0 6 7 *

Patient Name: _____

Patient Date of Birth: _____

Name of Person _____

Requesting Amendment: _____

Address to _____

Receive Notice: _____

Medical Records Use Only	
MRN #:	_____
HAR#:	_____

Home Telephone Number: _____

You have the right to request (Check One):

- Atrium Medical Center Atrium Pharmacy

to make corrections or amendments to the medical and 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 provide as much detail as possible regarding the correction or amendment you seek in your medical information. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "my laboratory test results from ABC laboratory of December 5, 2000 show a blood test I never received" or "Dr. Jones in your North Street Clinic recorded in my record on December 5, 2000 that I was suffering from weakness in my right leg when in fact the weakness is in my left leg." In order to review the requested correction, we must be able to locate the record in issue and the exact entries or reports you want corrected.

Please state as precisely as possible how you would like to see the record worded.

If you are aware of anyone else (such as your physician, pharmacist, clinic, etc.) who also may have a copy of the record you seek to have corrected, please list those persons or facilities here with as much information as you have available regarding names and addresses.

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Date: _____	Date: _____

I hereby authorize the indicated organization listed above to notify the persons/entities I have listed above that may have a copy of the record I seek to have corrected and to provide them with the amended information.

Signature: _____ Date: _____

Note that no Amendment Request will be processed unless the patient or the patient representative has signed this form.

If patient representative is completing this form, provide documentation or explanation of your authority to act for the patient: _____

ATRIUM MEDICAL CENTER
AMENDMENT REQUEST FORM
 39581 (12-10)

PLACE LABEL HERE

Name: _____

MR #: _____

HAR: _____