Request for Amendment to Medical Record

BEFORE COMPLETING THIS FORM, PLEASE NOTE: Amending the medical record does not mean that the original entry will be altered or deleted; a separate entry may be made to correct or clarify the original entry.

PATIENT NAME: _____

First MI LAST MAIDEN OR OTHER NAME

DATE OF BIRTH: _____ MEDICAL RECORD #: _____

MM/DD/YYYY

ADDRESS: _____

Street City State Zip

PREFERRED PHONE NUMBER: _____ EMAIL ADDRESS: _____

AMENDMENT REQUEST

TO EXPEDITE, PLEASE ATTACH A COPY OF THE MEDICAL RECORD DOCUMENT(S) YOU ARE REQUESTING TO BE AMENDED

Date(s) of Service: _____

Clinician of Record: _____

Hospital/Clinic/Practice Name: _____

Describe what you feel is incorrect about the entry: _____

_____

_____

To provide additional detail, please complete Attachment A

How did you learn about this error? ☐ During a visit ☐ Reviewing a copy of my medical records ☐ MyChart patient portal

☐ Other: _____

If granted, would you like us to notify persons/organizations who may have previously received this information? If so, please specify the name(s) and address(es) below. If additional space is needed, please attach a form with the additional names and addresses.

Name of Person or Entity	Address

I understand that my request will be responded to within 60 days, or I will be informed in writing of the need for an extension of not more than 30 days to process the request. I understand that this request for amendment will be reviewed by the responsible clinician(s) and may be denied pursuant to applicable rules. If denied, I will be informed in writing and have the right to submit a written statement disagreeing with the denial. I further understand that I have a right to file a complaint to the respective Privacy Officer of Yale Health and/or Yale New Haven Health and/or Yale Medicine or file a complaint to the Secretary of the U.S. Department of Health and Human Services concerning my request for amendment. If denied, this documentation will become part of my legal health record and will be released with any future disclosures.

_____ _____

Signature of Patient or Authorized Representative** **Date**

If not patient, please indicate relationship: _____

***Must provide proof of legal authority (except parent of a minor)*

Please complete and submit this form in person at Yale Health or:

Email: *yhmedicalrecords@yale.edu* *or* ***Postal Mail:*** *Yale Health, PO Box 208237, New Haven, CT 06520-82327* *or* ***Fax:*** *203-436-5536*

Amendment Request is: ☐ **Accepted** ☐ **Denied**

If denied, reason for denial (check one):

☐ **Information considered accurate and complete** ☐ **Information not created by our organizations**

☐ **Information is not available for patient to access by federal law** ☐ **Information is not part of designated record set**

Yale HEALTH

ATTACHMENT A

PLEASE REVIEW FOR ACCURACY OF DOCUMENTATION				
Date of Service	**Provider Facility**	**Name of Provider**	**Incorrect Entry**	**Suggested Entry**