Confluence HEALTH

HEALTH INFORMATION MANAGEMENT (HIM)
REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

DATE: _____

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Patient Phone: _____

Patient Mailing Address: _____

☐ **I request a change to my records.**
Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record:** _____

_____

_____

_____
Patient or legally authorized individual signature Date

_____
Relationship to patient if signed on behalf of the patient
by parent, legal guardian, personal representative, etc.

We will review your request and respond within 10 days of receiving your request. A copy of your request will be added to your record.

☐ We have received your written request for amendment dated _____. We try to respond promptly to all such request. Unfortunately, due to unusual circumstances, we have not been able to complete our review of your request. We need additional time to respond to your request. We expect to be able to provide a response to you not later than _____. We are sorry for the delay and appreciate your patience.

☐ This is to inform you that your request to amend medical records has been granted. Your records will be amended and the following providers, agencies and organizations will be notified of such amendment:

- ☐ anyone you identify, and
- ☐ anyone who received the information in the past and who needs to know about the change.

_____

You may contact HIM Department, if you have any additional questions requiring more information or want to report a problem about the handling of your information. Please fill out and return this form to: P.O. Box 3510, Wenatchee, WA 98807.

If you believe your privacy rights have been violated, you may contact our Privacy Officer, at Confluence Health by calling 509-663-8711. We respect your right to file a complaint with us or with the Secretary of Health and Human Services.