



REQUEST TO AMEND MEDICAL RECORD

607 West Main • Grangeville, ID 83530 • 208-983-1700 • www.syringahospital.org

I, _____, request that Syringa General Hospital and Clinics to change/amend my medical record because (Explain below what is to be changed/amended and why (may also submit a separate document of explanation):

For my medical record to be more complete or accurate, it should say (may also submit as a separate document):

Patient signature: _____ Date of request: _____

Printed name _____ Date of birth: _____

Follow-up:

Date request received: _____ Action must be taken by SHC within 60 days of the receipt of request.

After review, the author of the original entry (physician or other health care provider) will initial below if he/she agrees or disagrees with this request.

_____ The amendment/correction is accepted as requested; the change is to be made part of the medical record

_____ Request denied for the following reason:

- The information addressed is not part of the patient's designated record set and is not subject to correction/amendment by SHC.
- The original information is accurate and complete.
- Under HIPAA regulations the patient is restricted from accessing or amending this information.

_____ The author of original entry requests a 30-day extension to respond for the stated reason:

Signature of author of original entry: _____ Date _____

On date) _____ (name) _____ filed a statement of disagreement to SHC denial of his/her request for amendment. Date of original request: _____.

SHC's response to this statement of disagreement as follows:

Signature of Privacy Officer _____ Date _____

This form is to be filed in the patient's medical record.