PROVIDENCE Health & Services

SWEDISH

PATIENT REQUEST TO AMEND A DESIGNATED RECORD SET

This form must be complete and legible in order to be processed.

Top Section: Complete all fields.

Section 1: Fill in this section with the name of the provider who recorded the information, the date of service, the specific report where the item is to be corrected, e.g. Discharge Summary, History & Physical, etc. Under explanation, state the correction that needs to be made. If extra space is required, include an additional page with this request.

Section 2: If we decide to change the information as you requested, we will send the change to any person who received the information before it was changed. Complete this section if you wish us to send the amended documents to another party, such as an insurance company or an attorney. If there is more than one party that need a copy, include an additional page with this request.

Section 3: The patient usually signs this form. If a personal representative completes this form on behalf of the patient, proof of authority must be provided.

Important: The physician or provider may or may not supplement the record with an addendum based on this request. The physician or provider cannot alter the original documentation in the record. Your request may be denied If:

- We did not create the information or the person who did create it is not available to act on your request to change it (for instance, the originator has passed or moved away);
- The information is, in our judgment, accurate and complete;
- You do not have the legal right to view or access the information you want to change;
- The information is not part of the medical and/or billing records we use to make decisions about your care, treatment, and payment.

A letter of acceptance or denial will be provided within the legal time frame of your residential state. If you disagree with the denial letter, all documents related to the request for amendment will become part of your permanent medical record and will be included with any future authorized disclosures. If you have any concerns with this request, please contact Providence Health & Services at:

Health Information Management
P.O. Box 4950
Portland, OR 97208
Phone (855) 234-2491 Fax: (855) 234-2493

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Patient's Name: _____ DOB: _____

Address: _____ Phone: _____

For which state you are requesting this amendment:

☐ Alaska ☐ California ☐ Montana ☐ Oregon ☐ Washington

1. I request to make an amendment/correction to the documentation made by: (physician)

_____ on this date: _____

at this facility: _____

To document or section: _____

Explanation of requested changes (you may attach a separate page if needed):

_____

2. Please send a copy of the amended documents to this company or individual:

Name: _____

Address: _____

We will also send the amendment to other persons that we know have received the information if they relied, or might in the future rely, on the information to your detriment or harm.

3. _____ Date: _____

Signature of Patient or Personal Representative

If personal representative signs this request on behalf of the patient, complete the following:

Print Name: _____

Relationship to Patient: ☐ Power of Attorney for Healthcare* ☐ Legal Guardian*

☐ Parent ☐ Other

*Attach legal documentation if you are the legal guardian or Power of Attorney for Health care

For Internal Use Only

Date Received:_____ Initials _____ MRN_____

Sent to: _____ Date: _____

◯ Amendment Accepted. Corresponded with patient/representative on this date: _____

◯ Denied: Reason: _____

Revised April 2017