Please fill out the following as completely as possible:

Patient Name: _____ DOB: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Date of entry to be amended: _____

Type of entry to be amended: _____

Author of entry to be amended: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

Name _____ Address _____

I understand I will be notified in writing of the determination of the request for amendment.

Signature of Patient/Legal Representative: _____

Date: ____/____/____ Relationship to Patient: _____

CHI FRANCISCAN HEALTH MEDICAL STAFF USE ONLY

❑ I concur that the amendment should be incorporated into the medical record.

❑ I do not agree that the revisions should be incorporated into the medical record.

❑ I partially agree that the revisions should be incorporated into the medical record.

Signature of Health Care Practitioner _____ Date: _____ Time: _____

FOR CHI FRANCISCAN HEALTH HOSPITAL USE ONLY:

Amendment has been:

Date Request Received: _____ ❑ Approved ❑ Denied

Type of photo identification verified: Driver's License _____ Military I.D. _____

Other: _____ Initials: _____ Date: _____
(Please specify)

CHI Franciscan Health

597177

(04/01/15)

PATIENT AMENDMENT REQUEST