BRONSON

Affix Patient Label

Request Amendment to Medical Record

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: _____ Medical Record #: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone #: _____ Evening Phone #: _____

Entry to be Amended:

Date: _____ Type: _____

Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (You may append one type written page of at least 10-point font to this document.)

_____

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, specify:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

I understand that I will receive a copy of this form and that my request will be processed within 60 days or I will be informed of the need for an extension of not more than 30 days to process the request. I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement disagreeing with the denial which must be contained on not more than one handwritten or typewritten page of at least 10-point font. All information relative to my request for amendment will be linked to my records and disclosed to anyone for whom I authorize disclosure of information relative to the amendment or those who may have relied upon information that is now amended. I further understand that I may file a complaint concerning my request for amendment to Bronson Healthcare Group, 601 John St. Kalamazoo, MI 49007, or to the U.S. Department of Health and Human Services. (Our privacy office can provide you with the address.)

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Personal Representative _____

Interpreter's Statement: I have interpreted the text on this form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

DATE RECEIVED:

☐ Information you have requested be amended to your medical or billing record has been made a part of your permanent record and a copy has been sent to individual(s) you designated or others who may have previously received relied upon the amended information.

☐ Your request for amendment has been made a permanent part of your medical or billing record, but the amendment itself has been denied for the following reasons:

- ☐ The information you want amended was not created by this organization.
- ☐ The information you want amended is not a part of your medical or billing record.
- ☐ The information you want amended is not available for your access as required by federal law.
- ☐ The information you want amended is complete and accurate.

Signature of Practitioner: _____ Title: _____ Date: _____ Time: _____

FOR OFFICE USE ONLY

Copy amendment to:

☐ _____ by _____ Date: _____

☐ _____ by _____ Date: _____

(Send completed pages to Bronson HIM Department 601 John St. Box F Kalamazoo, MI 49007)