Request for Amendment of Medical Record

Patient Name: ____DOB:________________________

Address: ____

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Home Phone: (________) ______________________ Work/Cell Phone: (________) ____________________

Reason for Request:

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I understand the physician may or may not supplement the medical record with an addendum based on my request, and under no circumstances, is able to alter the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

Specify the Amendment(s):

Please be as specific as possible about date of note(s), document name, and author of note.

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Signature: ____ Date: _________________

Return form to:

Morris Hospital & Healthcare Centers
Attention: Health Information Management
150 W. High St.
Morris, IL 60450

- Office use only- -

MH# 1307 10/2017 *Original to HIM* *Copy to Patient* Date of Receipt: ____/____/____ DD#_______________