Children's Mercy

# Request for Amendment to Health Information

8071-178 MR 04/17

| Patient's Full Name and Previous Names Used | Date of Birth | MRN (internal use only) |
|---|---|---|
| | / / | |

| Patient Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

**Information to be Amended:** If multiple amendments are requested please complete a single form per request.

Date of Entry to be Amended: _____

Type or title of Entry to be Amended: _____

Please explain how the entry is incorrect or incomplete? What would you like the entry to say to be more accurate?

**Additional Disclosures:** Would you like this amendment sent to anyone to whom we may have received the information in the past?

Name and/or Organization: _____

Telephone Number: _____ Fax Number: _____

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

I acknowledge that the health care provider may or may not supplement the medical record with an amendment based on my request. I understand that this form and any subsequent information pertaining to this request will be included as part of the permanent medical record.

| Printed Name of Patient, Parent, or Legal Guardian | Relationship to Patient | ( ) – Telephone Number |
|---|---|---|
| | | |

| Signature of Patient, Parent, or Legal Guardian | / / Date |
|---|---|
| | |

**CMH Staff Use Only**

Date Request Received: _____

Amendment has been:

- ☐ Accepted
- ☐ Denied for the following reason (check one):
  - ☐ The Protected Health Information was not created by Children's Mercy Hospital.
  - ☐ The Protected Health Information is not part of the patient's "designated record set".
  - ☐ The Protected Health Information or record is not available to the patient for inspection as required by federal law.
  - ☐ The Protected Health Information is accurate and complete.

Health Care Provider Comments (if any):

_____

_____

| Signature of Health Care Provider | Printed Name/Title | _____/_____/_____ Date |
|---|---|---|
| | | |