Fort HealthCare
For Health.

For HIM Department Use Only:

PT MRN: _____
Date Received: _____
Date Completed: _____
Extension Needed: Yes No

REQUEST FOR AMENDMENT OF THE FORT HEALTHCARE MEDICAL RECORD

Patient name: _____

Date of birth: _____

Address: _____

City, state, zip code: _____

Phone number: ( )_____-_____

Submit your request to:
Fort HealthCare
Attn: HIM Dept. - Patient Amendment
611 Sherman Avenue East
Fort Atkinson, WI 53538

Fax: 920-568-5195 – Attn: Patient Amendment

Section A: To the Individual- Please read the following and complete the information requested.
You have the right to request that we amend the protected health information in your legal medical record that our business associates or we maintain. We have 60 days to process your request.

We may decline your request if:
- the information is not part of Fort HealthCare's legal medical record;
- we did not create the information;
- we believe the information is complete and accurate;
- the information is contained in psychotherapy notes;
- the information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding; or
- the original author of the documentation is no longer employed at Fort HealthCare
- the information is not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a).

Please specify which document(s), medical information and/or dates of service you wish to amend (if more space is needed, please attach additional form(s):

_____

_____

Please state the reason(s) and/or attach support for the amendment(s): _____

_____

_____

Section B: To the Individual- Please read the following and follow the instructions regarding the releasing of medical records.

Release of Information – If approved
If you would like a copy of your amended medical record sent to any previous or new recipients please complete the Release of Information form found at www.forthealthcare.com within the "Patient Info" section. Or you can contact the Health Information Management Department at (920) 568-5188.

Signature: _____ **Date:** _____ **Time:** _____

If this request is signed by a legally authorized representative on behalf of the individual, complete the following:

Representative's name: _____

If signed by a person other than the patient, please state relationship and authority to do so:

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Spouse of Deceased
☐ Health Care Agent _____
☐ Personal Representative/Domestic Partner of Deceased
☐ Other _____

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REQUEST FOR AMENDMENT OF THE FORT HEALTHCARE MEDICAL RECORD

Section C: Response to Amendment Request: Provider Section

____ Your request for an amendment has been **APPROVED**; a correction/addendum will be made part of your permanent medical record. A copy of the amended document(s) will be mailed to you.

____ Part of your request has been approved, please see below for more details. A copy of the amended document(s) will be mailed to you.

____ Your request for an amendment has been **DENIED;** your request has been made a part of your permanent medical record.

Your request was denied for the following reason reason(s):

☐ Fort HealthCare did not create the information, please follow up with _____
☐ The information is considered complete and accurate
☐ The information is contained in psychotherapy notes
☐ The information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding
☐ The information is not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a).
☐ You did not provide enough information to complete the request
☐ The request is regarding billing information and should be directed to: _____
☐ The original author of the documentation is no longer employed at Fort HealthCare

Additional Information:

_____

_____

_____

_____

Signature: _____ **Title:** _____ **Date:** _____ **Time:** _____

Section D: Patient Options and Contact Information:

If your request is denied:
You may submit a one page statement of disagreement regarding the denied request. If you do, we will append or link your statement to the medical record(s) you wanted amended for inclusion in future disclosures of those records. We may prepare and send you a rebuttal to your statement of disagreement and, if we do, we will append or link our rebuttal to those same records for inclusion in future disclosures of those records.

Instead of submitting a written statement of disagreement, you may request in writing that your request to amend those records and this denial be appended or linked to those records to be included with future disclosures.

Additional Contact Information:
If you have questions, wish to discuss the denial or review your options; please contact:
HIM Manager (920)-568-5180

If you would like to file a complaint or discuss the quality of your care, please contact Quality Dept. at (920)568-5179.