Mon Health™ Medical Center

MR-101

MON HEALTH MEDICAL CENTER
ATT: HIM DIRECTOR
1200 JD ANDERSON DRIVE
MORGANTOWN, WV 26505

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

PATIENT NAME: _____ DOB _____

MEDICAL RECORD NUMBER: _____ ACCOUNT NUMBER:_____

ADDRESS: _____

PHONE NUMBER (H): _____ (W): _____

AFTER REVIEW OF MY MEDICAL RECORD, I DO NOT FEEL THE ORIGINAL DOCUMENTATION MADE BY:

_____ TO BE ACCURATE/RELEVANT/TIMELY/COMPLETE ON THE FOLLOWING SERVICE DATE(S): _____ AND SHOULD BE SUPPLEMENTED WITH CLARIFYING INFORMATION IN THE FORM OF AN ADDENDUM TO THE MEDICAL RECORD.

I UNDERSTAND THE AUTHOR 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. SHOULD THE REQUEST FOR AMENDMENT BE ACCEPTED, I UNDERSTAND THAT I MUST AUTHORIZE RELEASE OF THE AMENDED INFORMATION AS IT CAN NOT BE RELEASED WITHOUT MY WRITTEN AUTHORIZATION.

SHOULD MY REQUEST FOR AMENDMENT BE DENIED, I UNDERSTAND THAT I HAVE THE RIGHT TO SUBMIT A WRITTEN STATEMENT OF DISAGREEMENT TO THE FOLLOWING:

PRIVACY OFFICER
MON HEALTH MEDICAL CENTER
1200 J.D. ANDERSON DRIVE
MORGANTOWN WV 26505

SECRETARY OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVENUE, S.W.
WASHINGON DC 20201

I REQUEST THE FOLLOWING AMENDMENT BE MADE ON MY MEDICAL RECORD:

_____

_____

SHOULD MY REQUEST FOR AN AMENDMENT BE DENIED:

__ I WANT MY DENIED REQUEST FOR AN AMENDMENT BE MADE PART OF MY PERMANENT MEDICAL RECORD.

_____ _____
SIGNATURE (PATIENT OR LEGAL REPRESENTATIVE) DATE

RESPONSE

YOUR REQUEST FOR AMENDMENT HAS BEEN DENIED FOR THE FOLLOWING REASONS:

_____

_____

_____ _____
SIGNATURE DATE

PLACE PATIENT LABEL HERE