HEALTH RECORD CORRECTION/AMENDMENT FORM

Policy No.: ________________________

Insured Name: ____ Insured Birth Date: ________________

Address: ____

SSN: ____ Date of Entry to be amended: ________________

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete.

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Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name and address of the individual or organization.

Name and Address: ____

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____ ___________________________

Signature Date

FOR AMERICAN COMMUNITY'S USE ONLY:

Patient Name: ____

Date Amendment Request received: __________________ Amendment Status: ___ Accepted ___Denied

If Amendment Request is denied, check reason for denial:

_____ The Protected Health Information was not created by this organization

_____ The Protected Health Information is not available to the patient for inspection as required by law

_____ The Protected Health Information is not part of the patient's health record

_____ The Protected Health Information is accurate and complete

_____ Other

Name of Staff Member: ____________________________________Title: ___________________________