McLaren
HEALTH CARE

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____**Patient Birth Date:** _____ **/** _____ **/** _____

Patient Address: _____

Date(s) of entry to be amended: _____ / _____ / _____

Describe in detail the requested amendment, the type of record (e.g., Progress Note) to be amended, and the reason for such amendment in the space provided below:

_____
_____
_____
_____
_____
_____
_____

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(s) and address(es) of the individual or organization below:

_____
_____
_____

Signature of Patient or Legal Representative: _____ Date: __ / ___ / ___

Send completed form to:
McLAREN HEALTH CARE PRIVACY OFFICER
One McLaren Parkway, Grand Blanc, MI 48439; or
Privacy@McLaren.org

FOR McLAREN HEALTH CARE USE ONLY:

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 (e.g., psychotherapy notes).
_____ The Protected Health Information is not part of the patient's health record.
_____ The Protected Health Information is accurate and complete.

Name and Title of Compliance Staff: _____

Comments of Healthcare Practitioner: _____

Signature of Healthcare Practitioner: _____ Date: ___ / ___ / _____