GRANDE RONDE HOSPITAL

Patient's full name:
_____

Date of birth: _____

HEALTH RECORD CORRECTION/AMENDMENT FORM

Date of entry to be corrected: _____

Author of original documentation: _____

In detail, please explain how the information entered on your health record is incorrect or incomplete:

_____
_____
_____
_____
_____
_____

By providing your signature below, you are stating that you understand all of the following:

1. The physician or healthcare provider may or may not supplement your medical record with an addendum based on this request.
2. The physician or healthcare provider is not allowed to alter the original document in your medical record.
3. This request for amendment will be made a permanent part of your medical record and will be sent with any future authorized medical record requests for information.

Grande Ronde Hospital will provide a response to this request within sixty (60) days. You will have the opportunity to provide a statement of disagreement should the physician or healthcare provider deny this request.

_____ _____

Signature of patient or legal representative Date

_____

Phone number

GRANDE RONDE HOSPITAL

Patient's full name:
_____

Date of birth:_____

HEALTH RECORD CORRECTION/AMENDMENT FORM

Should this request be approved by the physician or healthcare provider, do we need to send a copy of the correction/amendment to anyone we may have disclosed this information to in the past? If so, please provide the name and address below, and we will send a copy of the amendment as soon as it is approved and available.

Name and address: _____
_____
_____
_____

PROVIDER RESPONSE

❒ An amendment will be made to your permanent health record.
❒ This request for an amendment has been made a part of your permanent record. However, your request to amend your health record directly has been denied for the following reasons:

_____
_____
_____
_____

_____ _____ _____
Provider Signature Date Time

If you disagree with the provider's response, you may submit a written statement.
(Attach copy of Statement of Disagreement for patient)