PATIENT REQUEST TO AMEND THE HEALTH RECORD

Patient Name ________________________________ Date of Birth ________________

Address ____

City ________________________ State ___________ Zip Code __________________

Home Phone______________________ Work Phone ____________________________

I have reviewed my health record; I do not feel the information is correct:

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This date(s) of service ______________________ should be updated with the following information: ____

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This form may be returned to your clinic or mailed directly to:

Lake Region Healthcare
Health Information Management Department
712 Cascade St. S.
Fergus Falls, MN 56537
Fax: (218) 736-8757

Signature ____ Date: ________________

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:

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Provider Signature __________________________________ Date __________________

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