REQUEST FOR AMENDMENT TO MEDICAL RECORD

1 R O I

Patient Name: _____ Date of Birth: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: _____

Date(s) of Service: _____

Date of entry to be amended: _____

Note: The original medical record cannot be altered. Any approved amendment will be noted in the record.

Please explain the amendment you are requesting.

_____

_____

_____

_____

_____

_____ _____

Signature of Patient or Authorized Representative Date

If signed by other than patient, indicate relationship or authority:
Patient is: ☐ a Minor ☐ Incompetent ☐ Deceased ☐ Other
I am: ☐ Legal Guardian ☐ Next of Kin of Deceased ☐ Executor of Estate

Refer to Notice of Privacy Practices for more information on your right to amend health information.

For Office Use Only:

Date Received: _____ Amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial*:

☐ Health information was not created by this organization

☐ Health information is not part of patient's designated record set

☐ Health information is not available to the patient for inspection as required by Federal Law (e.g., psychotherapy notes)

☐ Health information is accurate and complete

Staff Processing Request: _____
Name Date WFH Organization

* NOTE: Reference from 42C.F.R.§§164.526.

Wheaton Franciscan Healthcare

☐ Franklin
☐ St. Francis
☐ Wheaton Franciscan Medical Group

Wheaton Franciscan
☐ Elmbrook Memorial Campus
☐ St. Joseph Campus
☐ Wisconsin Heart Hospital Campus

Request For Amendment To Medical Record

79468 08/2013 R4

Place patient label here if available

Name _____

Date of Birth _____

Chart ID _____