

**Request for Amendment to Medical Record**

BEFORE COMPLETING THIS FORM, PLEASE NOTE: Amending the medical record does not mean that the original entry will be altered or deleted; a separate entry may be made to correct or clarify the original entry.

PATIENT NAME: \_\_\_\_\_  
First MI LAST MAIDEN OR OTHER NAME

DATE OF BIRTH: \_\_\_\_\_ MEDICAL RECORD #: \_\_\_\_\_  
MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
Street City State Zip

PREFERRED PHONE NUMBER: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

**AMENDMENT REQUEST**

*TO EXPEDITE, PLEASE ATTACH A COPY OF THE MEDICAL RECORD DOCUMENT(S) YOU ARE REQUESTING TO BE AMENDED*

Date(s) of Service: \_\_\_\_\_

Clinician of Record: \_\_\_\_\_

Hospital/Clinic/Practice Name: \_\_\_\_\_

Describe what you feel is incorrect about the entry: \_\_\_\_\_

**Please provide additional detail on page 2**

How did you learn about this error?  During a visit  Reviewing a copy of my medical records  MyChart patient portal  
 Other: \_\_\_\_\_

If granted, would you like us to notify persons/organizations who may have previously received this information? If so, please specify the name(s) and address(es) below. If additional space is needed, please attach a form with the additional names and addresses.

Name of Person or Entity	Address

*I understand that my request will be responded to within 60 days, or I will be informed in writing of the need for an extension of not more than 30 days to process the request. I understand that this request for amendment will be reviewed by the responsible clinician(s) and may be denied pursuant to applicable rules. If denied, I will be informed in writing and have the right to submit a written statement disagreeing with the denial. I further understand that I have a right to file a complaint to the Privacy Officer of Yale New Haven Health and/or Yale Medicine or file a complaint to the Secretary of the U.S. Department of Health and Human Services concerning my request for amendment. If denied, this documentation will become part of my legal health record and will be released with any future disclosures.*

Signature of Patient or Authorized Representative\*\* \_\_\_\_\_ Date \_\_\_\_\_

If not patient, please indicate relationship: \_\_\_\_\_

\*\*Must provide proof of legal authority (except parent of a minor)

Please complete and submit this form to: **Email: [AmendmentRequest@ynhh.org](mailto:AmendmentRequest@ynhh.org)** or  
**Postal Mail: Yale New Haven Health, HIM Documentation Integrity, PO Box 9565, New Haven, CT 06535**

**PROVIDER RESPONSE**

Date: \_\_\_\_\_

Amendment Request is  Accepted  Denied If denied, reason for denial (check one):

- Information considered accurate and complete
- Information is not available for patient to access by federal law
- Information not created by our organizations
- Information is not part of designated record set



