Yale Medicine | Yale NewHaven Health

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: *HIMAmendmentRequest@ynhh.org* *or* ***Postal Mail:*** *PO Box 9565 HIM Documentation Integrity New Haven, CT 06535*

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

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

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PLEASE REVIEW FOR ACCURACY OF DOCUMENTATION				
Date of Service	**Provider Facility**	**Name of Provider**	**Incorrect Entry**	**Suggested Entry**

Interpretation Services (if necessary): An interpreter facilitated the communication between the health care provider(s) and the patient or authorized patient representative in _____ (language) to assist in obtaining informed consent or sharing/acknowledging information.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: _____ AM/PM Date: _____

Check here if: ☐ Telephone ☐ Video ☐ In person ☐ Bilingual Competency Program Approved Staff

ID Number (telephone/video only): _____

_____ Print Name of Interpreter

_____ Signature of **Interpreter (in-person only)**

YHS000509 (N 01/23)
Available in Spanish