

Request for Amendment to Medical Record

Patient Name: _____
Last First Middle Maiden or other name

Date of Birth: ____/____/____ Address: _____
Month Day Year

City: _____ State: _____ Zip: _____ Telephone: _____

Date of service: ____/____/____ Provider name: _____
Month Day Year

Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?
(You may append one typewritten page of at least 10-point font to this document.)

How did you learn about this error: During visit with a Yale Health provider Review of copy of medical records
 MyChart patient portal Other

If granted, would you like this amendment sent to anyone to whom we may have disclosed the information in the past?
If so, specify:

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

I understand that I will receive a copy of this form and that my request will be processed within 60 days or I will be informed of the need for an extension of not more than 30 days to process the request. I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement disagreeing with the denial which must be contained on not more than one handwritten or typewritten page of at least 10-point font. All information relative to my request for amendment, including this form, will be linked to my records and disclosed to anyone for whom I authorize disclosure of information relative to the amendment. I further understand that I may file a complaint concerning my request for amendment within 180 days of making the request to Yale Health or the Secretary of the U.S. Department of Health and Human Services.

Signature of patient or legal guardian Date If not signed by patient, please include your relationship to patient

PHYSICIAN/PROVIDER DETERMINATION AFTER MEDICAL RECORD REVIEW

Amendment Request is: Accepted as accurate (see attached addendum) Accepted as alternate viewpoint Denied

If denied, reason for denial: (Check one)

- Information is considered complete and accurate Information is not available to the patient for access as required by federal law
 Information was not created by this organization Information is not part of patients designated record set

Provider Signature: _____ Printed name: _____ Date: _____