REQUEST FOR AMENDMENT OF HEALTH/BILLING RECORD

Patient Name: _____ Birth Date: _____

Primary Physician: _____

After review of the □ health □ billing record of the patient listed above, I do not feel the original documentation made by _____ accurately or completely reflects the patient's treatment, condition, diagnosis or other information on the following date(s): _____ and should be amended by adding clarifying information to the medical record.

I understand St. Luke's may or may not agree that the Health/Billing record is inaccurate and may deny the request for amendment. If the record is amended, I understand the amendment will be made a permanent part of the record and will be included in any future authorized release of the record. If St. Luke's refuses to amend the record, I understand I may provide a statement of disagreement to be filed with and accompany the record in any future authorized release of the record.

I understand the provider will either respond to this request for amendment within 60 days of receiving it or inform me of any delay in its ability to respond within that timeframe.

1. Reason(s) for Amendment: _____

_____

_____

2. Identify what entry(ies) need amendment: _____

_____

_____

3. What should the entry(ies) say to be more accurate or complete? _____

_____

_____

4. Has anyone received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? **Yes** □ **No** □

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

_____

_____

I agree that St. Luke's may provide copies of the amendment to the above-identified organization/individual if it accepts my request for amendment.

Signature of Patient or Legal Representative _____

Date

For Internal Use Only

Date Received: _____
Assigned To: _____
Date Completed: _____
Response Letter Sent: _____
Amendment Status: _____

_____ ACCEPTED
Date entered in chart: _____
Changes entered by: _____

If accepted, any other treating providers will be sent amended information.

_____ DENIED
Reason for denial:
_____ Information was not created by this organization
_____ Information is not part of the patient's medical record
_____ Federal law forbids making the information in question available to the patient for inspection
_____ Existing information is accurate and complete

COMMENTS:_____
_____
_____
_____

Signature of Privacy Officer: _____
(Required for unresolved complaints) Date