Middlesex Health

CC4656

Request for Amendment/Correction of Protected Health Information

The responsible provider will review your request and may either agree or disagree with your request. If the Amendment/Correction is agreed to, your original request and the amendment will be made a part of your medical record. It is unlawful to remove any portion of your medical record. For that reason, any changes made will be in the form of an addendum. The facility has 60 days to respond to this request unless notification is provided of the need for a thirty-day extension.

Patient Name:_____ DOB:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Primary Telephone #:_____ ☐ Check, if Cell Phone

Middlesex Health Facility:_____ Physician Office:_____

Date(s) of entry to be amended:_____

List of document(s) to be amended:_____

_____

Please explain the reasons for your request to amend your medical record and state the corrections below. Please attach copies of documentation and clearly identify areas of concern.

_____

_____

_____

_____

_____

_____

_____

Signature of Patient or Legal Representative:_____ Date:_____

If not Patient, (State Relationship): _____ (Legal Documentation Required)

Forms can be faxed to Health Information Management at 860-358-6366, or mailed to:

Middlesex Health
Health Information Management
28 Crescent Street
Middletown, CT 06457

You may request your original Amendment/Correction request and/or your disagreement with the denial be included as part of your legal medical record.

Physician Response:

- **Agreed.** - Please see addendum to the medical record dated:_____
- **Denied.** -The request is denied for the following reason(s): _____

_____

_____

Provider Signature:_____ **Date:**_____ **Time:**_____