Indiana University Health

Request for Amendment of Health Record Form

Patient Label

First Name:_____ Middle:_____ Last Name:_____

Date of Birth:_____ Medical Record Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: (home) (_____)_____ (work) (_____)_____

This form is used through all IU Health Affiliated Covered Entity (IU Health) facilities and physician practices.

Entry to be Amended:

Date:_____ Type:_____

Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

_____

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

Name:_____

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

Whether your amendment is approved or denied, you will get a written response within 60-90 days from the Health Information Management Department at IU Health (HIM). Under no circumstances are we able to alter or delete the original entry of the medical record. This request for an amendment will be made part of your permanent medical record and will be sent as part of the medical record with any future requests.

_____ _____

SIGNATURE (Patient or Legal Representative) DATE

RESPONSE

☐ *Your amendment request was **APPROVED**. This amendment will be made part of your permanent medical record.*

*This request will be made a part of your permanent medical record; however, your amendment has been **DENIED** for the following reason(s):*

☐ IU Health did not create the information you requested to amend.
☐ Federal law does not authorize access to the information you requested to amend.
☐ The information was not a part of the patient's designated record set.
☐ The original information was deemed accurate and complete.
☐ Provider is deceased or no longer affiliated with Indiana University Health.

If your amendment is denied, you have the right to submit a written statement of disagreement to Health Information Management Department at IU Health. If a statement of disagreement is submitted, IU Health may submit a rebuttal statement, a copy of which would be provided to you.

_____ _____ _____

SIGNATURE DEPARTMENT/TITLE DATE