Request for Amendment/Correction to Medical Record

Please complete, sign and return this form to: Or submit via fax to 617-414-4210. Contact us 617-414-4213 with questions.
Director of Health Information Management
Boston Medical Center
Medical Record Department
850 Harrison Avenue/ACC Basement
BR-09E
Boston, MA 02118

Section l: Completed by Patient or Legal Representative

Patient Name: _____
Last Name First Name Middle

Address: _____
Street City State/Zip Code

Date of Request:____/__/____**Medical Record #:**_____**Birth Date:**____/____/____Telephone # _____

I request that the following information be amended/corrected in my medical record: (What should the entry say to be more accurate or complete?) Please specify the respective date(s) of service. If necessary, you may append one typewritten page of at least 10-point font to this document.

Reason for Request: (Please explain why the entry is incorrect or incomplete):

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

- ☐ I understand that I will receive a copy of the this Form and that my request will be processed in 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 if I do not submit a written statement of disagreement, I may ask for my request for amendment/correction to be included in any disclosure of the information to which the disagreement relates.

Copy of Document in Question Attached: ϒ yes ϒ No

Patient/
Legal Representative Signature:_____**Date:**____/____/____**Relationship:** _____

Section ll: Completed by BMC Authorized Personnel

Request approved: ϒ yes ϒ No Date:____/____/____
Updated Document(s): ϒ paper record ϒ electronic/online record ϒ both

Healthcare practitioner 's Comments/Special Instructions: _____

If your request has been denied, you may:

- **You may submit a statement disagreeing with the denial**
- **You may request that your original amendment/correction request and denial be attached to future disclosures of your protected health information.**
- **You may file a complaint with BMC Privacy Officer, Boston Medical Center, Medical Record Department, ACC Basement/BR-09E, Boston, MA 02118-2393; or with the Secretary of Health & Human Services.**

Please maintain a copy of this form for your records

Section lll: Completed by HIM Director

Notice of Determination sent to Patient or Legal Representative: _____

Reason(s) for Denial:

- ☐ **BMC did not create the information**
- ☐ **Information not a part of the medical record**
- ☐ **The responsible healthcare practitioner deemed the information accurate and complete**
- ☐ **The information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative action and where applicable law would prohibit the organization from disclosing the information to the patient because the information would jeopardize the safety of the patient and others**
- ☐ **CLIA**

Authorized Hospital Representative: _____

Title: _____

Date: _____