

Willamette Falls Hospital

**REQUEST FOR AMENDMENT OF THE MEDICAL RECORD**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone# \_\_\_\_\_

After review of my medical record, I do not feel that the original documentation made by \_\_\_\_\_ accurately reflects my treatment, condition, or diagnosis on the following date \_\_\_\_\_ and should be supplemented with clarifying information in the form of an addendum to my medical record.

I understand that the physician or health care provider may or may not supplement my record with an addendum based on my request. I understand that my physician or other health care provider is not allowed to alter the original documentation in my record. I understand that my request for amendment will be made a permanent part of my medical record and will be sent with any future authorized medical record request for information.

I understand that the hospital will provide a response to this request within sixty days. I understand I have the opportunity to provide a statement of disagreement should my physician or health care provider deny my request.

**Reason for amendment:** \_\_\_\_\_

**I request the following correction/amendment be made on my medical record:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician or Health Care Provider Response**

\_\_\_\_\_ In response to your request, a correction/addendum will be made part of your permanent medical record.

\_\_\_\_\_ Your request has been denied; however, your request is made part of your permanent medical record. The reason your request is denied:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date response sent to Patient: \_\_\_\_\_ by \_\_\_\_\_