Request for Amendment of Medical/Billing Record

Patient Name: _____ Birth date: _____

Street Address: _____ Phone: _____

City, State, Zip: _____

After review of the medical record, I do not feel the entry made on (date)_____ by (name)_____ is correct. The entry does not accurately reflect my treatment, condition, or diagnosis.

I would like to add a statement to change the medical record. I understand that:

- My medical team may or may not agree to the amendment (correction). If St. Luke's refuses to amend my 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.
- St. Luke's will add this amendment request to my medical record.
- St. Luke's will respond to this request within 60 days of receiving it or will inform me of any delay in its ability to respond within that timeframe.

Please explain how the entry is wrong or incomplete. What should the entry say?

_____

_____

_____

_____

Would you like this amendment sent to anyone who received or relied on this information (such as your doctor, pharmacist, health plan, or other health care provider)? If yes, please provide the name and address of the organization or individual below.

_____

_____

_____ _____

Signature of Patient or Legally Authorized Representative Date/Time

Please return the completed form to: St. Luke's Medical Records, 915 E 1st Street, Duluth, MN 55805. Alternatively, you may email the signed form to RequestRecords@slhduluth.com Please note that unencrypted email is not secure and the email could be intercepted by a third party.

Patient Label

For Internal Use Only

Date Received: _____

Patient Name, DOB, and MRN: _____

Assigned to: _____

Provider response:

I've reviewed the request and my response is:

☐ Full acceptance ☐ Full denial

☐ Partial acceptance _____
Explanation

Reason for denial:

☐ Information was not created by this organization

☐ Information is not part of patient's medical record

☐ Information is accurate and complete

☐ Federal law does not permit patient to inspect the information

Comments: _____

_____

_____

Date Completed: _____

Signature of Privacy Officer: _____ _____
Date/Time

Response Letter Sent: _____

Patient Label