Ear, Nose & Throat Center

Request for Amendment

Patient Name: _____

Date of Birth: _____ Chart Number: _____

I have recently reviewed my medical record as documented by Dr. _____. I feel that he has not clearly indicated the correct information in regard to my condition, treatment, or diagnosis for my visit on _____. I feel that this information should be corrected or clarified by adding an addendum to my medical record.

I understand that Dr. _____ may or may not addend my medical record based on this request. The original document can not be altered and should reflect the true episode of care in regard to condition, treatment, and/or diagnosis. If Dr. _____ feels the addendum is not appropriate then this request shall remain as part of the permanent medical record and should be included in any request for disclosure of protected health information.

Please make the following correction to my medical record.

_____

_____

_____

_____

_____

Signature Date

Amendment Response

☐ Correction/Addendum made. Date _____

☐ Amendment request made part of medical record. Addendum denied for the following reason(s):

_____

_____

_____

_____

Signature Date