Request for Amendment of Protected Health Information

Request Date: _____

Individual Name:_____ Date of Birth:_____ SSN: _____

Patient Address: _____

Telephone Number: (H)_____(W) _____

Medical Record No.: _____

After review of my medical record, I am requesting that information on the following service date(s)_____be amended/supplemented with certain information and added in the form of an addendum to my medical record. I am requesting this amendment because: _____

_____

I understand that BJC Medical Group may or may not amend/supplement my medical record based on my request and under no circumstances, can BJC Medical Group alter the original documentation of my medical record.

Amendment Request:

I request the following amendment/supplement be made to my medical record:

_____

_____

_____

_____

_____

Signature (Patient or Legal Representative) Date

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other healthcare provider)?

___Yes____No

If yes, please specify the name(s) and address of the organization(s) or individual(s):

_____

_____

_____

For BJC Medical Group Use Only:

Amendment has been:____Accepted____Denied

_____ In response to your request, an amendment/supplement will be made part of your medical record.
_____ Your request has been denied for the following reasons:
_____ The information is accurate and complete.
_____ The information was not created by this BJC Medical Group.
_____ The information is not part of the Designated Record Set.
_____ Federal law prohibits making the Information available to the patient for inspection (e.g. psychotherapy notes).
_____ Other: _____

Staff comments: _____

_____

_____

Signature of Staff person_____ Date _____

Print Name & Title _____

Statement of Disagreement:
If you do not agree with the above, you may submit a Statement of Disagreement that will become part of your medical record and included in any future disclosure of the subject medical information. Please outline the reason for your disagreement in the space provided below: (may attach no more than 2 pages)

□ I do not wish to submit a Statement of Disagreement. However, I am requesting that BJC Medical Group include in any future disclosure my request for amendment form and BJC Medical Group's denial.

_____

Signature (Patient or Legal Representative) Date

Mail this form to:

BJC Medical Group
670 Mason Ridge Center Drive
Suite 300
St. Louis, MO 63141
Attn: HIM Department