

**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)

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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.

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Signature (Patient or Legal Representative)

Date

Mail, Email or Fax this form to:

BJC Medical Group  
660 Mason Ridge Center Drive  
Suite 300  
St. Louis, MO 63141  
Attn: HIM Department  
Fax: 314-996-7008  
Email: BJCMG\_HIM@bjc.org

**\*\*The above address  
is for mail only\*\***