Dana-Farber Cancer Institute

Request for Amendment in Medical Record

Patient Name: _____ **Date of Request:** _____
Last Name First Name Middle

Address: _____ **Medical Record Number:** _____
_____
_____ **Date of Birth:** _____

Contact telephone number: _____

(This section to be completed by patient)

I request the following information to be amended in my medical record: *(Please specify Date(s) of Service and name of Provider):*

Date(s) of Entry to be Amended:

_____
_____
_____

Reason for Request:

_____
_____
_____

If possible, please enclose with this request copies of the specific information to be amended.

If your request is denied:

- **you may submit a statement disagreeing with the denial**
- **you may request that your original amendment request and/or your disagreement with the denial be attached to future disclosures of your personal health information**
- **you may file a complaint with the institution or the U.S. Department of Health and Human Services**

If your request is approved, please list person(s) that have received your personal health information that need to see the amendment:

Please include name, title and phone number.

_____
_____
_____

Patient/Guardian signature: _____ **Relationship:** _____

The facility has 60 days to respond to the amendment request from the date of receipt. If the facility is unable to act on the request within 60 days, an extension of 30 days may be required. If an extension is required, notification will be provided along with a written explanation.

(This section to be completed by Hospital or Physician Office)

Copy of Document in Question Attached: ☐ yes ☐ no
Request approved: ◯ yes ◯ no Date amendment implemented: _____

Updated Document(s): ☐ paper record ☐ electronic/online record ☐ both

Amendment made:
_____
_____
_____

Request denied: ◯ yes ◯ no

Reason for denial:

☐ Protected Health Information (PHI) was not created by this organization
☐ Protected Health Information (PHI) is not part of the patient's designated record set
☐ Protected Health Information (PHI) is unavailable to the patient for inspection
☐ Protected Health Information (PHI) is accurate and complete according to author

Comments of Health care practitioner:
_____
_____
_____

Author signature: _____ DATE: _____ TIME: _____

Notification of Determination sent to Patient/Requestor on: _____
Date
Authorized Hospital Representative: _____ Title: _____ Date: _____
