SYRINGA HOSPITAL & CLINICS

Patient Request to Amend Health Record

607 West Main • Grangeville, ID 83530 • 208-983-1700 • www.syringahospital.org

Patient Name: _____ Date of Birth: _____

Address: _____ Medical Record #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)_____ Work Phone: (____)_____

Please describe the information you want amended. Include the date(s) of entry, if known.

_____

_____

Please explain your reason for making this request.

_____

_____

_____

Please explain how the entry is incomplete or incorrect and how you would like it changed.

_____

_____

_____

If the amendment is accepted, please list individuals or organizations who have received copies of your record that you would like us to notify of the amendment.

_____

_____

Signature: _____ Date: _____

If signed by legal representative, relationship to patient: _____

Return form to: **Syringa Hospital & Clinics, Attn: Health Information Management, 607 West Main, Grangeville, ID 83530** or fax to **208-983-8520**.

Provider Response

☐ An amendment will be made to your permanent health record.

☐ This request for amendment has been made a part of your permanent record; however, your request to amend your health record directly has been denied for the following reasons:

_____

_____

Signature: _____ Date: _____

If you disagree with the provider, you may submit a written statement of disagreement.