Central Montana Medical Center
Health Information Management

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH *(mm/dd/yyyy)*	PATIENT RECORD NUMBER

PATIENT ADDRESS

DATE OF ENTRY TO BE CORRECTED/AMENDED *(mm/dd/yyyy)*	INFORMATION TO BE CORRECTED/AMENDED

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Use additional sheets if needed and attach to this form.

Would you like this amendment sent to anyone else who received the information in the past? ☐ Yes ☐ No
If yes, specify the name of the organization(s) or individual(s).

I understand that the provider may or may not supplement the medical record with an addendum based on my request, and under no circumstances is able to alter the original medical record. In any event, this request for an addendum will be made part of my permanent medical record.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

FOR CMMC USE ONLY

DATE RECEIVED	AMENDMENT HAS BEEN
	☐ ACCEPTED ☐ DENIED

IF DENIED, CHECK REASON FOR DENIAL

☐ Protected Health Information (PHI) is not part of the patient's designated record set

☐ Record is not available to the patient for inspection under Federal law

☐ IHS did not create record

☐ Record is accurate and complete

COMMENTS OF HEALTHCARE PROVIDER *(If applicable)*

SIGNATURE OF HEALTHCARE PROVIDER *(If applicable)*	TITLE	DATE *(mm/dd/yyyy)*
SIGNATURE OF CUSTODIAN OF RECORD		DATE *(mm/dd/yyyy)*