**University of Minnesota Physicians**
720 Washington Ave SE, Suite 200
Minneapolis, MN 55414
Phone: 612-884-0650
Fax: 612-884-0907
Email: HIM-department@umphysicians.umn.edu

**MRN:** _____
*for office use only*

## Request for Amendment of the Medical Record

Patient Name: _____ DOB: _____

Address: _____

_____ Phone Number: _____
*(City)* *(State)* *(Zip)*

**Please provide the following details regarding your request for an amendment (or correction) to your medical record.**

- Date of the record entry in question: _____
- Name of the health care team member who created the entry: _____
- Type of record (e.g., visit progress note, discharge summary, etc): _____

_____

- Description of the information to be amended or corrected, including an explanation of why it is incomplete or inaccurate and a statement of the specific change requested:

_____
_____
_____
_____
_____

**Following a review of your request, including a review by your health care provider as necessary, it will be decided whether it can be accepted. It may be accepted in full or in part, or it may be denied. We will inform you of the decision as soon as we can, but the review process may take up to 60 days.**

If you know, list the names and addresses of other organizations or individuals who received the previous information from us and who you wish to receive the updated information if the changes are accepted:

_____

_____ _____
*Signature (Patient or Legal Representative)* *Date*

This form may be returned to your clinic, or sent directly to the address above, ATTN: HIM Dept.

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### HEALTHCARE PROVIDER RESPONSE

I've reviewed the requested changes and have made the following determination (check one):

☐ I accept the requested changes **in full** and will addend the record accordingly.

☐ I accept the requested changes **in part** and will addend the record accordingly.

☐ I do not accept the requested changes.

If the amendment is accepted in part, indicate which part was **denied:** _____

_____

If the amendment is denied **in full or in part,** indicate the reason for the denial:

☐ The information is accurate and complete.

☐ The information was not created by this organization.

☐ The information does not exist in the patient's record with this organization.

☐ The information is not part of the patient's record subject to an amendment.

☐ Other (provide explanation): _____

_____ _____
(Provider Signature) Date