AltaMed
QUALITY CARE WITHOUT EXCEPTION™

REQUEST TO AMEND

Patient/Participant/Client (P/P/C) Information:	*To be completed if person making the request is not the patient*:
Patient Name:	Name:
Date of Birth:_____/_____/_____	Verification of Identity/Authority:
Address:	Phone#:
City: State: Phone#:	Clinic Name:

Complete all areas below with as much detail as possible:

Date(s) of entry or entries to be amended: _____/_____/_____; _____/_____/_____; _____/_____/_____

Name of the report or type of entry: _____

Please explain how the entry is incorrect or incomplete: _____

Please explain how the entry should be changed to be correct or more complete:

If this amendment is approved, would you like the corrected information sent to anyone who may have received the information in the past? (Check One) ☐ Yes ☐ No

If yes, please specify the name(s) and address(es) of the person(s) or place(s).

Name:	Name:
Address:	Address:
Address:	Address:

By signing my name below, I am certifying that I am the patient or personal representative named above and that the information above is correct to the best of my knowledge.

AUTHORIZATION:

_____
Patient Signature Date

_____
Signature Date

If signed by someone other than patient, indicate relationship

- ☐ Parent/Legal Guardian
- ☐ Caregiver
- ☐ Durable Power of Attorney
- ☐ Other (Please Specify):_____
- ☐ Personal/Legal Representative

For more information about your privacy rights, see the "Notice of Privacy Practices" available at all AltaMed sites, or by sending a written request to AltaMed Health Services Corporation Attn: HIM Director at 2040 Camfield Ave. Los Angeles, CA 90040.
Email: RecordRequest@AltaMed.org | **Phone:** (323) 622-2444

For AltaMed Health Services Use Only:

To be completed by appropriate AltaMed staff:

Date Received:_____/_____/_____

Date Sent to Health Information Management Director either through interoffice courier or by email to RecordRequest@AltaMed.org :_____/_____/_____

Health Record Number:_____

To be completed by Author of Entry:
(Please mark whether request to amend is accepted or denied. If denied, please document reason.)

☐ Accepted

- ☐ Only part of the request will be amended and I will document an addendum in the EHR
- ☐ The entire request will be amended and I will document an addendum in the EHR

☐ Denied

- ☐ The PHI is accurate and complete
- ☐ The PHI was not created by this organization
- ☐ The PHI is not part of the designated record set
- ☐ The PHI is not available for inspection according to federal law (e.g., psychotherapy notes)
- ☐ Other:_____

Comments of Healthcare Provider/Author:

_____

_____

_____

_____

_____
Author Printed Name Title

_____
Author Signature Date