Michigan Medicine Revenue Cycle Mid Service **Patient Request for Amendment to the Medical Record**	Name: DOB: MRN:

Under the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act, the patient has a right to request health information be corrected/amended if they believe it is incorrect or incomplete. The healthcare provider will review the request and either grant (approve) the request or explain the reason why it will not be granted (denied).

Patient Name: _____ Date of birth (DOB): _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone # _____ Medical Record Number (MRN) _____

Date(s) of entry and type of information to be amended (e.g. problem list, office visit, procedure note, etc.).

I believe the information described above is incomplete or incorrect for the following reasons. You may also attach a copy of the challenged entry and identify its location in the medical record. Be as specific as possible.

Please write exactly what you think the entry should state to be accurate and complete.

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I authorize Michigan Medicine to send this amendment, to the following individuals or entities that received or relied on my protected health information (PHI) before it was amended.

Name & Address:

Name & Address:

I understand and acknowledge that:

- Amendments, if approved, are completed via addendums to the original information.
- This request for an amendment and any attached document will become part of my medical record regardless of the healthcare provider's decision.
- The request for an amendment may be denied if:
  - Michigan Medicine did not create the information
  - The information is accurate and complete
  - The information provided on this form cannot be found in the record
  - The information is not part of the designated record set
  - The information is not available for inspection in accordance with 45 CFR Section 164.524
  - The requestor did not sign and/or date the form. NOTE: a typed signature is **not** acceptable.
- If the healthcare provider is not able to act on this request within 60 days of receipt by the team that processes amendment requests, you will be notified of the delay.

_____ _____

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date

_____

Printed Name of Patient or Legally Authorized Representative

Relationship (check one): ☐ Self (patient) ☐ Parent ☐ Legal Guardian* ☐ DPOA of Healthcare*

*If other than the patient's or parent's signature, a copy of legal paperwork (court appointed guardian or durable power of attorney for healthcare (DPOA)), verifying the patient's representative **MUST** either be in the patient's record or accompany this request.

Return completed form by email, fax or mail to:
Revenue Cycle, Mid Service Data Integrity
3621 S. State St.
700 KMS Place, Bay 11
Ann Arbor, MI 48108-1633
Fax: 734-998-0187; Email: HIM-PtAmendment@med.umich.edu; Phone: 734-615-7705