MICHIGAN MEDICINE Revenue Cycle Mid Service (HIM) **Patient Request for Amendment to the Medical Record**	NAME: MRN: BIRTHDATE:

A patient who believes information in his/her record is erroneous or missing may request an amendment or correction to the record by using this form. ***NOTE: I understand the clinician may, or may not, choose to make the requested amendment. Original health information may not be removed or deleted. Amendments, if approved, are completed via addendums to the original documents***.

Patient Name: _____ Date of Birth: _____

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

Telephone #: _____ MRN (Medical Record Number): _____

1. **Clinician Name**: _____
2. **Date of entry** to be amended: _____
3. **Type of Information** to be amended (Office Visit, Procedure Note, etc.):

_____

_____

4. **Provide Specific Reason(s) for Amendment Request** (request may be denied if a reason is not provided): _____

_____

5. What change to the documentation do you believe would improve the accuracy of your information? Attach to this document any additional pages that support your position.

_____

_____

6. Optional: Check and/or complete if applicable

☐ If this amendment is made, I authorize Michigan Medicine to send this amendment, to the following individuals and/or entities that received or relied on my protected health information (PHI) before it was amended. Please indicate individuals and/or entities below:

Name: _____

Address: _____

Name: _____

Address: _____

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I understand and acknowledge that:

- This request for amendment and any attached documents, **will** become part of my medical record regardless of the clinician's decision.
- Michigan Medicine is under no obligation to agree to this request for amendment of my PHI.
- My request for an amendment may be declined/denied if: (1) we did not create the information or the person who did create it is not available to act on your request to change it (for instance, the originator has passed or moved away); (2) the request is not reasonable; (3) the information I provide is not accurate or cannot be found within record; (4) this form is not completed in its entirety; and/or I do not sign and date below. This form must be either digitally signed or printed and hand signed. Typed signatures will not be accepted.

_____ **Date:** _____/_____/_____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship: ☐ Spouse ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian ☐ DPOA for Healthcare

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g. court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen. For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an amendment request signed by the named individual. If the estate has not been probated a completed amendment request, death certificate and personal representation form all MUST be submitted.

Please return the completed form by email, fax or mail to:
Revenue Cycle Mid Service (HIM) Data Integrity
3621 S. State Street 700 KMS Place
Bay 11 - Mid Service
Ann Arbor MI 48108-1633

Phone: 734-615-7705 Fax: 734-998-0187 Email: HIM-PtAmendment@med.umich.edu