

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ **Patient Birth Date:** ____ / ____ / ____

Patient Address: _____

Name of McLaren facility where I received treatment:

(and/or) Name of McLaren provider who treated me:

Date(s) of documentation to be amended: ____ / ____ / ____

Describe in detail the requested amendment, the type of record (e.g., Progress Note) to be amended, and the reason for such amendment in the space provided below:

Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name(s) and address(es) of the individual or organization below:

Signature of Patient or Legal Representative: _____ Date: ____ / ____ / ____

Send completed form to:
MCLAREN HEALTH CARE PRIVACY OFFICER
 One McLaren Parkway, Grand Blanc, MI 48439; or
 Privacy@McLaren.org

MHC_CC1108.7.8

HIM Staff: Notify Compliance Officer of request immediately. Attempt to contact provider once per week (for 2 weeks only) and document outcome. After two weeks, refer request to Compliance Officer.	
Attempted/Contacted Provider: Date/Time: _____	Staff Signature: _____ Outcome: _____
Attempted/Contacted Provider: Date/Time: _____	Staff Signature: _____ Outcome: _____
Compliance Staff: Request accepted <input type="checkbox"/> Request denied <input type="checkbox"/>	
Reason for denial, if applicable: _____	Date patient notified of outcome: _____