McLaren Medical Group

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

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

Patient Address: ____

Date of entry to be amended: _____ / _____ / _____

Describe in detail the requested amendment and reason for such amendment in the space provided below:

____

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____

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 and address of the individual or organization below:

Name(s) and Address(es)

____

____

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____

____

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

FOR McLAREN MEDICAL GROUP USE ONLY:

Amendment Status: ❑ Accepted ❑ Denied

If Amendment Request is denied, check reason for denial:

_______ The Protected Health Information was not created by this organization.

_______ The Protected Health Information is not available to the patient for inspection as required by law (e.g., psychotherapy notes).

_______ The Protected Health Information is not part of the patient's health record.

_______ The Protected Health Information is accurate and complete.

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name:

Date of Birth:

McLaren Ambulatory Care Center,
McLaren/Bay Occupational Health and/or Convenient Care Center
REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Name of Staff Member: ____

Title: ____

Comments of Healthcare Practitioner:

____
____
____
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____
____
____
____

Signature of Healthcare Practitioner: ______________________ Date: _____ / _____ / _____

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name:

Date of Birth: