MEDICAL RECORD AMENDMENT/CORRECTION FORM

**Name:**  Phone Number:

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street or PO Box)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip)

1. Date of Medical Record Entry to be Corrected\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Document in the Medical Record and what you believe needs to be Amended/Corrected (attach a copy if possible):

3. Your desired Amendment/Correction:

4. Reason for the Amendment/Correction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please help us identify persons who have received the Information (prior to Amendment/Correction) The Right Door will send the amended record (if approved) to those indivuals/entities that previously had the information disclosed to them:

Name Organization/Address Phone Number

( )

( )

( )

( )

( )

1. Do you authorize us to provide the information in Items no. 3 and no. 4 to the persons/organizations listed in Item no. 5?

Yes

No - Do not provide the information to:

**TO OUR PATIENTS: You have the right to submit a Medical Record Amendment/Correction Sheet to be made a part of your medical record. This right does not permit you to alter or change the original record created by your provider or their staff.** **We may deny your request to amend or correct your records.**

Amendment/Correction **Accepted**  Amendment/Correction **Denied**

Reason for Denial

This Amendment/Correction Sheet Is to Be Made a Part of the Medical Record of:

(Patient Name) (Date)

Signature of Patient Date

The Right Door has up to 60 days to amend the record or to notify you of a denial of your request. If we have denied your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).

If we have denied your requested amendment/correction and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this document with any future disclosures of the information identified in Items no. 1 and no. 2 above. Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our “Notice Of Privacy Practices” or our legal obligations under state or federal law, you may contact the Compliance Officer regarding your complaint, and you may file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.

REFERENCE

Michigan Mental Health Code - 330.1749 Statement correcting or amending information. Sec. 749. A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record. The recipient, guardian, or parent of a minor recipient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record.