Ko-Kwel Wellness Center

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Information

Name of Patient: _____

Date of Birth: _____ Account #: _____

Date of Request: _____ Phone: _____

Address: _____

Address to which a response shall be sent (if different than above):

_____

WHAT NEEDS TO BE AMENDED	
Entry to be Amended	
Date and Author of Entry	

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete.
Would you like this amendment sent to anyone to whom we may have disclosed this information in the past outside of Ko-Kwel Wellness Center? If so, please specify the name and address of the organization or individual.

Ko-Kwel Wellness Center

I understand that the provider may or may not supplement the medical record with an addendum based on my request, and under no circumstances is able to alter the original medical record. In any event, this request for an amendment will be made part of my permanent medical record.

_____ _____

Patient/Authorized Representative Signature Date

FOR INTERNAL USE ONLY

This section is to be completed by the reviewer.

Date Received:	Review Date:
Reviewed By:	Title:

The request is: ☐ Granted ☐ Denied

☐ Individual was informed of denial in writing. (Attach Amendment Denial Letter)

☐ Individual has requested amendment/denial be included with any future disclosures of protected health information. (Must be requested in writing and attached to this document.)

Reviewer's Comments:
(If the request is denied, indicate the reason.)

_____ _____

Reviewer Signature Date

_____ _____

Privacy Officer Signature Date