We encourage you to provide complete information to help us process your request efficiently. Incomplete submissions may result in delays.

You may be contacted to verify your identity. If you are submitting this request on behalf of the patient, documentation proving your legal authority may be required.

Requests to update insurance, demographic information, or primary care provider details are typically handled directly by the location where care was received. Please contact that location for assistance with these types of updates.

Section A: Patient Information:

Patient Name (First, Middle, Last)	Patient Date of Birth (mm/dd/yy)
Street Address:	City State Zip
Phone Number ( )	Email Address

Section B: Preferred method of communication where communication regarding this request will be sent. CHECK ONE:

_____ Email Address Listed Above _____ Street/Mailing Address Listed Above

Section C: Description of Health Information you are requesting to be amended:

1. Date(s) of the documentation to be amended (*This may be the date of medical record entry, clinic visit, date of note entry, procedure date or other service):
   _____

2. Location of the documentation you are requesting to be amended: If possible, attach a copy of the documentation, and use blue or black ink to circle the information you believe is inaccurate.

   Check all that apply:

   ☐ Procedure Note ☐ Progress Note ☐ History and Physical Note ☐ Discharge Summary Note

   ☐ Consultation Note ☐ Past Medical History ☐ Surgical History ☐ Problem List ☐ Family History

   ☐ Social History ☐ Medication List ☐ Flowsheet ☐ Lab/Imaging Results

   Other:_____

3. Please specify how you would like the records to be stated. Please note that while your request will be thoroughly reviewed, the final amendment may not match the exact wording submitted. Sharing how you would like the record to read helps us understand your concerns and ensures they are evaluated carefully.

   Example 1: Please change statement ABC to statement XYZ.

   Example 2: Please delete statement ABC from my health record.

_____

_____

_____

_____

_____

_____

Section D. Acknowledgement:

By submitting this form, I request that the organization amend or correct my health information as described above. I understand and acknowledge that the organization is required to respond within 60 days of receiving my request, and that I will be notified if an additional 30-day extension is necessary.

If my record is amended, I understand and acknowledge that the organization will inform me of the outcome and will notify any relevant individuals or entities with whom the amendment must be shared. I further understand and acknowledge that the organization is not required to agree to my request.

If my request is denied, I will receive a written explanation of the denial. If I disagree with the explanation, I may submit a written statement of disagreement, or I may request that my amendment request and the denial explanation be included with any future disclosures of the health information that is the subject of the requested amendment.

Print name of patient or representative: _____

Print relationship to patient if not patient: _____

Signature: _____Date: _____

Return this form and any additional documentation by:

Email: amendmentrequests@tgh.org

Fax: 813-844-1239