PATIENT REQUESTED AMENDMENT FORM

Patient Name (Please print): Date:

Patient Address:

Date of Entry requested to be amended or corrected:

Type of Entry requested to be amended or corrected:

Please explain your requested amendment/correction. What do you disagree with or what do you believe the entry should be? *(If additional space is needed, please check this box ☐ and attach a separate piece of paper)*

Would you like this amendment sent to anyone to whom we may have disclosed the incomplete or inaccurate information in the past? If so, please specify the name and address of the organization or individual (*Attach additional sheets if necessary*).

Name: Address:

Name: Address:

I understand that my request will be considered and will become a permanent part of my medical record (regardless if the amendment was granted or denied), including any future authorized requests for release of my Protected Health Information (PHI).

I understand that I will receive a response within 60 days. If WellSpan is unable to act on the amendment within 60 days, WellSpan may notify you that an extension of 30 days is needed. WellSpan may only have one extension of 30 days to act on my request.

Signature of Patient or Legal Representative:

Date:

- For WellSpan Use Only -

Date Received: MRN:

Amendment has been: ☐Accepted ☐Denied

If denied, check reason for denial:

☐ Information was not created by WellSpan Health
☐ Information is not part of the individual's designated record set
☐ Information is not available to the individual for inspection under Federal law (e.g., psychotherapy notes)
☐ Information is accurate and complete
☐ WellSpan Provider is no longer available

Completed by: Date:

Please return this form to:
jshorts2@wellspan.org