Beth Israel Deaconess HealthCare

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete the following information:

1. Today's Date: _____
2. Patient's Full Legal Name: _____
3. Date of Birth:_____ 4. Patient Tel. #_____
5. Patient Street Adress: _____

   City: _____ State: _____ Zip_____
6. Describe the information you want amended (eg. lab results, physician notes) and the reasons why you believe the information is incorrect or incomplete? (Please attach written statement if needed.)

   _____

   _____
7. Date(s) of information to be amended (eg. date of office visit, treatment, or other health care services)

   _____
9. Do you know of anyone who may have received or relied on the information in question (eg. doctor, pharmacist, health plan or other health care professional? If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

   _____

   _____
11. If amendment is accepted, do we have your permission to share the amendment with individuals who have received this information? /__/ Yes /__/ No

PATIENT RIGHTS

You will receive a reply within <u>60 days of receipt of request for amendment</u> unless a 30 day extension is requested by us.
If your request for amendment is "approved".

1) We will notify all healthcare professionals identified by the patient of the amendment; and
2) We will notify other parties or business associates who may have relied on this information for patient care; and
3) We will amend and update all medical records in our possession.

Your request for amendment may be "denied" based on the following:

1) The information was not created by this organization; or
2) The information is not part of the patient's designated record set; or
3) The information is accurate and complete; or
4) The information is not available to the patient for inspection as required by state and/or federal laws (eg. psychotherapy notes).

You have the right to submit an appeal in writing if you disagree with the denial.
Please submit all appeals to our Compliance Officer at the following address:

Jacqueline Miranda
Beth Israel Deaconess HealthCare
464 Hillside Avenue, Suite 304
Needham, MA 02494
(617)754-0541

You have the right to request that any future release of your medical information includes the requested amendment and denial information.
You have the right to file a complaint with the Secretary of HHS.

PATIENT SIGNATURE

Please read the following statement and check the box below.

/__/ I understand that Beth Israel Deaconess HealthCare, in accordance with Massachusetts State and/or Federal Laws, may or may not amend my medical record based on this request, and under no circumstances will alter the original documentation of the medical record. In any event, this request for an amendment may be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

X_____

Patient / Legal Representative Signature

FOR OFFICIAL USE ONLY

Amendment has been: /___/ Accepted

/___/ Denied. Please choose reason:

/___/ The information was not created by this organization; or

/___/ The information is not part of the patient's designated record set; or

/___/ The information is accurate and complete; or

/___/ The information is not available to the patient for inspection as required by state and/or federal laws (eg. psychotherapy notes).

/___/ Determination letter attached

Physician Signature: _____ Date: _____

Compliance Officer Signature: _____ Date: _____

If Approved:

/__/ All appropriate parties affected have been notified
Notification letters attached. By Whom: _____ Date: _____

/__/ Amendment has been filed in the medical record By Whom: _____ Date: _____