FIRELANDSHEALTH

AMENDMENT REQUEST FORM

You have the right to request Firelands Regional Health System to make corrections or amendments to the medical and health information we retain on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request but each request will be carefully reviewed and corrections or amendments made if warranted. You will be notified in writing, when your request has been approved or denied.

Name:_____DOB:_____

SS#:_____ Contact phone number:_____

Requestor's address:_____

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Please provide as much detail as possible regarding the correction or amendment you seek in your medical information. Be as specific as possible regarding the report you would like modified.

Please state as precisely as possible how you would like to see the record worded:

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I hereby authorize Firelands Regional Health System to notify the persons/entities that may have a copy of the record I seek to have corrected and to provide them with the amended information.

Signature_____Date_____

Note that no amendment request will be processed unless you or your representative has signed this form. If patient representative, provide the appropriate documentation of your authority to act for the patient.