Menninger®

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Patient Name_____ Medical Record #_____

SSN_____ D.O.B._____

Address_____ City_____

Phone (H)_____

State_____ Zip Code_____ (W)_____

After review of my medical record, I do not feel the original documentation made by _____ accurately reflects my condition/diagnosis/treatment on the following service date(s)_____ and should be supplemented with clarifying information in the form of an addendum to the medical record.

I understand the physician/clinician 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 documentation of the medical record. In any event, this request for an addendum will 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.

I request the following corrections/supplementation be made on my medical record:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature (Patient or Legal Representative) **Date**

Physician/Clinician's Response

_____ *In response to your request, a correction/addendum will be made part of your permanent medical record.*

_____ *Your request has been made a part of your permanent medical record; however, your request has been denied for the following reasons:*

_____

_____

_____

_____

_____

_____ _____

Clinician Signature **Date**

File the original in the medical record and give a copy to the patient.