

Request for Correction or Amendment of the Medical Record

Name of Patient _____

Birth Date _____

Address _____

Phone (home) _____

City, State, Zip Code _____

Phone (work) _____

UW Medicine entity:

- | | |
|---|---|
| <input type="checkbox"/> Harborview Medical Center & Clinics
<input type="checkbox"/> Northwest Hospital & Medical Center & Clinics
<input type="checkbox"/> Valley Medical Center & Clinics
<input type="checkbox"/> University of Washington Medical Center & Clinics
<input type="checkbox"/> UW Medicine Neighborhood Clinics | <input type="checkbox"/> University of Washington Physicians <i>(billing records only)</i>
<input type="checkbox"/> Hall Health Center
<input type="checkbox"/> Summit Cardiology |
|---|---|

I believe that the medical information made by (provider name): _____
 does not correctly show my condition/diagnosis/treatment on the following date(s): _____
 and should be corrected.

I understand:

- The original information in my medical record cannot be changed, but a comment, statement, or clarifying note can be added to the record.
- My care provider may not agree with my request to amend my record.
- If my request is denied, my amendment request and the denial will be filed in my medical record, but will only be released if I make that request.

I request the following correction to my medical record *(Please include reason why)*:

If more space is needed, more pages can be attached.

Signature (Patient or Legally Authorized Surrogate Decision Maker) _____

Date _____

You may send completed form to:

UW Medicine Health Information Management

325 Ninth Ave. Box 359738
 Seattle, WA 98104
 Fax: 206.744.9997
 Phone: 206.744.9000
 Email: uwmedroi@uw.edu

Northwest Hospital & Medical Center

Mail: 1550 North 115th St., D-129
 Seattle, WA 98133
 Fax: 206.668.1920
 Phone: 206.668.1616

Valley Medical Center

Mail: Release of Information
 400 S 43rd Street
 P.O. Box 50010
 Renton, WA 98058
 Fax: 425.656.4026
 Phone: 425.251.5159
 Email: Recordsrequest@valleymed.org

For Provider Use Only

Provider Please Return To: _____ Box _____ After Review

- In response to this request, a correction/addendum will be made part of your permanent medical record.
- This request has been made a part of your permanent medical record; however, your request for amendment has been denied for the following reason(s): _____

Provider Signature

NPI

Date

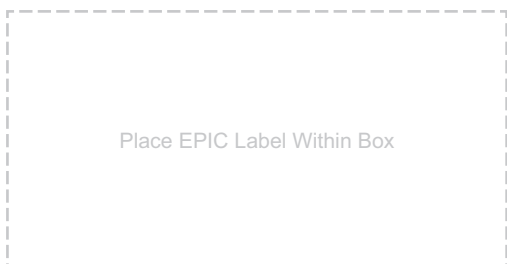
Time

For Office Use Only: Sent to Patient: (Date) _____ **By** (Name) _____

PT.NO

NAME

DOB



UW Medicine

Harborview Medical Center – Northwest Hospital & Medical Center
 Valley Medical Center – UW Medical Center
 University of Washington Physicians Seattle, Washington

REQUEST AMENDMENT OF MED RECORD



UH2078

UH2078 REV SEP 17

WHITE – MEDICAL RECORD
 CANARY - PATIENT

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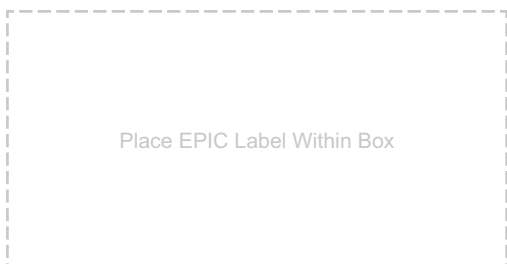
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PT.NO

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DOB



UW Medicine

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 Valley Medical Center – UW Medical Center
 University of Washington Physicians Seattle, Washington

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