

# 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<br><input type="checkbox"/> UW Medical Center & Clinics - Montlake<br><input type="checkbox"/> UW Medicine Primary Care<br><input type="checkbox"/> UW Physicians ( <i>billing records only</i> ) | <input type="checkbox"/> UW Medical Center & Clinics - Northwest<br><input type="checkbox"/> Valley Medical Center & Clinics<br><input type="checkbox"/> Hall Health Center |
|--|---|

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:

**Harborview Medical Center and Clinics**  
**UW Medical Center and Clinics - Montlake**  
**UW Medical Center and Clinics - Northwest**  
**UW Medicine Primary Care Clinics**  
**Hall Health Center**  
Mail: 325 Ninth Ave. Box 359738  
Seattle, WA 98104  
Fax: 206.744.9997  
Phone: 206.744.9000  
Email: uwmedroi@uw.edu

**Valley Medical Center and Clinics**  
Mail: Release of Information  
400 S 43<sup>rd</sup> Street  
P.O. Box 50010  
Renton, WA 98058  
Fax: 425.690.9407  
Phone: 425.690.3406  
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)**

**UW Medicine**

Harborview Medical Center – University of Washington Medical Center  
UW Medicine Primary Care – Valley Medical Center – UW Physicians

**REQUEST AMENDMENT OF MED RECORD**

Page 1 of 1



879076

UH2078 REV JAN 22

WHITE – MEDICAL RECORD  
CANARY - PATIENT

PLACE PATIENT LABEL HERE