Request for Correction or Amendment of the Medical Record

Name of Patient _____ Birth Date _____

Address _____ Phone *(home)* _____

City, State, Zip Code _____ Phone *(work)* _____

☐ Valley Medical Center & Clinics

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)* Print Name Date

You may send completed form to:

Valley Medical Center and Clinics
Mail: Release of Information
400 S 43rd 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 **Print Name** **NPI** **Date** **Time**

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

Patient Label