AAR

Patient Name	Date of Birth	Medical Record Number
Address	Home Telephone Number	Work Telephone Number

After review of my medical record, I do not feel the original documentation made by the following physician, caregiver, or other hospital employee on the service date(s) indicated below accurately reflects my condition / diagnosis / treatment and should be supplemented with clarifying information in the form of an addendum to the medical record:

Caregiver:

Services Date(s):

I'm amending my medical record by adding the following information:

_____

_____

_____

_____

_____

_____

_____

I understand the caregiver may or may not supplement the medical record with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical record. In any event, this request for an amendment 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.

Patient Signature or Authorized Party	Date/Time

Caregiver Response

- ❑ I agree with your request and have added a late entry to the body of the medical record.
- ❑ Your request has been made a part of your permanent medical record; however, I do not agree for the following reasons:

_____

_____

_____

_____

_____

Caregiver Signature	Date/Time

Medical Record Amendment Request
QHC-HIM-3401HMS 01/07 (Rev. 3/09) Page 1 of 1
ORIGINAL - Medical Record COPY - Recipient COPY - Department

Patient Label