McLaren
HEALTH CARE

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ **Patient Birth Date:** _____ / _____ / _____

Patient Address: _____ **Phone:** _____ **Email:** _____

Name of McLaren facility where I received treatment:

(and/or) Name of McLaren provider who treated me:

Date(s) of documentation to be amended: _____ / _____ / _____

Describe in detail the requested amendment, the type of record (e.g., Progress Note) to be amended, and the reason for such amendment in the space provided below:

_____

_____

_____

_____

_____

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_____

Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name(s) and address(es) of the individual or organization below:

_____

_____

_____

Signature of Patient or Legal Representative: _____ Date: _____ / _____ / _____

Send completed form to:

McLAREN HEALTH CARE PRIVACY OFFICER
One McLaren Parkway, Grand Blanc, MI 48439; or
Privacy@McLaren.org

HIM Staff: Notify Compliance Officer of request immediately. Attempt to contact provider once per week (for 2 weeks only) and document outcome After two weeks, refer request to Compliance Officer.
Attempted/Contacted Provider: Date/Time: _____ Staff Signature: _____ Outcome: _____
Attempted/Contacted Provider: Date/Time: _____ Staff Signature: _____ Outcome: _____
Compliance Staff: Request accepted ☐ Request denied ☐
Reason for denial, if applicable: Date patient notified of outcome: _____

PT.

MR.#/RM

DR.