PALOMAR HEALTH

Instructions for Completing the Medical Record Correction/Amendment Form

1. Patients or Legal Guardians have the right to request an amendment to their protected health information created by Palomar Health at any time while the organization maintains the information. All requests for amendment to their protected health information must be submitted in writing.

2. Please complete the **Medical Record Correction/Amendment Form on the next page**. Include what you feel the information should say to be more accurate or complete in 250 words or less. Include the name of the document that needs to be corrected/amended. (For example; Emergency Department Physician Notes, History & Physical Report, or Consultation Note.) **If you have a copy of the document, please submit it with the Medical Record Correction/Amendment Form and circle or highlight the information that you feel is inaccurate or incomplete.**

3. Return the completed **Medical Record Correction/Amendment Form** and supporting documentation to the attention of Palomar Health Medical Records, 120 Craven Road, Suite 224, San Marcos, CA 92078.

4. Palomar Health will provide notification of agreement or denial of the patient's request no later than 60 days after receipt. A 30-day extension may be obtained if needed.

5. If the request for amendment is approved, the amendment will be added to the medical record.

6. If the request for the amendment is denied, the Patient or Legal Guardian has the right to resubmit a written rebuttal statement.

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Medical Record Correction/Amendment Form

Patient First Name:_____ **Patient Birth Date:**_____

Patient Last Name:_____ **Patient Medical Record Number:**_____

Patient Address:_____ **Financial Number to be Amended:**_____

_____ **Date of Entry to be Amended**:_____

_____ **Document Name:**_____

Explain how the information entered on your medical record is incorrect or incomplete. Include what you feel the information should say to be more accurate or complete in 250 words or less. **Please continue your documentation on the back side of this form, if additional space is needed.**

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_____ _____

Signature of Patient or Legal Representative **Date**

FOR (ORGANIZATION'S) USE ONLY:

Date Amendment Request received:_____
Amendment Status:_____Accepted _____Denied

If Amendment Request is denied, check reason for denial:

_____ The Protected Health Information was not created by this organization.
_____ The Protected Health Information is not available to the patient for inspection as required by law (e.g., psychotherapy notes).
_____ The Protected Health Information is not part of the patient's medical record.
_____ The Protected Health Information is accurate and complete.

Name of Staff Member:_____**Title:**_____

Comments of Healthcare Practitioner: (use backside of this form, if additional space is needed.)

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_____ _____

Signature of Healthcare Practitioner **Date**