SIU MEDICINE

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REQUEST FOR AMENDMENT TO MEDICAL RECORD

Patient Name: _____ Date of Request: _____

Address: _____ Date of Birth: _____

Contact telephone number: _____

Please specify the information you are requesting be amended in your medical record. Use as much detail as possible. Attach additional pages if needed.

What is the reason for this amendment request?

What does the current information say that you believe is inaccurate?

What change to the documentation do you believe would improve accuracy of your information?

I understand I have the right to request an amendment to my health information maintained in a designated record set at SIU Medicine. I understand that SIU Medicine is not always required to make the amendments I requested; however, my request for amendment will be reviewed and amendments will be made when warranted. I understand that I will receive a written response regarding my request to amend within 60 days. If SIU Medicine denies my request, I will receive an explanation of why and what my options are.

Signature of Patient: _____ Date: _____

Relationship if not Patient: _____

*If other than patient's signature, a copy of legal paperwork verifying the patient's personal representative must accompany the request (e.g. court appointed guardian, durable power of attorney for healthcare). Exception: parent signing for a minor patient.

Send Form to: SIU Medicine Privacy Office, P.O. Box 19639, Springfield, IL 62794-9639, Fax- (217) 545-1884