Cleveland Clinic

# Request for Amendment of Health Information

**NOTE: Sections A, B & C of this form must be completed in full (please print clearly) and the form must be signed and dated. Submission of an incomplete form may delay processing your request.**

| **SECTION A – Patient information:** | |
|---|---|
| Patient Name (First, Middle and Last) | Cleveland Clinic Medical Record # |
| Current Address (Mailing address if different from current address) | City State Zip |
| Last 4 Digits of Social Security Number | Phone Number ( ) Date of Birth / / |

**SECTION B – Description of health information you are requesting to be amended:**

1. Information requested to be changed:

| **Date of Visit/Service** | **Information Type** (Office visit, ER note, Procedure Note, etc.) | **Provider Name & Facility** (if known) |
|---|---|---|
| | | |
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| | | |
| | | |

2. What is the reason for this change (amendment) request?
   _____
   _____

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

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

**SECTION C – Understanding your right to request an amendment of your health information:**

I understand I have the right to request an amendment to my health information maintained in a designated record set at Cleveland Clinic. I understand Cleveland Clinic is not always required to make the amendments I have requested; however, my request for amendment will be carefully 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 Cleveland Clinic denies my request (in whole or in part), I will receive an explanation of why it was denied and what my options are.

Signature of Patient/Patient's Personal Representative*: _____ Date:_____

Printed Name : _____ Relationship, if not Patient : _____

***If other than the 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 health care). Exception: parent signing for a patient under the age of eighteen. For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an amendment request signed by the named individual. If the estate has not been probated, a completed amendment request, death certificate and personal representation form all MUST be submitted.***

**Please send this form to:** Health Information Management, Attn: EHR, RK2-1 6801 Brecksville Rd, Independence, OH 44131