REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip Code: _____

For Health Information Management Office Use Only:
PT MRN: _____
Date Received: _____
Date Completed: _____
30-Day Extension Needed: Yes No

Submit your request to:
Altru Health System
ATTN: HIM Manager
P.O. Box 6002
Grand Forks, ND 58206-6002

Section A: To the Individual - Please read the following and complete the information requested. (If more space is needed please attach additional sheets.)

You have the right to request that we amend the protected health information in your medical record that we or our business associates maintain. This request will become a component of your medical record. We will respond to your request within 60 days of our receipt of this request, unless a 30-day extension is deemed necessary, in which case we will notify you of the extension and the reason for it.

We may decline your request if:

- The information is not part of Altru's medical record;
- We did not create the information;
- We believe the information is complete and accurate;
- The information is contained in psychotherapy notes;
- The information is compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding;
- The original author of the information is no longer practicing at Altru Health System.

Please explain below in detail what should be changed/addended and why:

_____
_____
_____
_____
_____
_____

For my medical record to be more complete/accurate, it should say:

_____
_____
_____
_____
_____
_____

Section B: To the Individual – Please read the following.

Release of Information – If approved

If you would like a copy of your amended medical record sent to any previous or new recipients, please complete the Release of Information Authorization form found at Altru.org/patients-visitors/records within the "Release/Transfer of Medical Records" section. Or contact Altru Medical Records at 701.780.6145 or toll-free at 800.437.5373, ext. 6145.

Signature of Individual or Individual's Representative: _____ Date: _____

Printed Name and Relationship, if not Individual: _____
(If other than individual's signature, a copy of legal paperwork verifying the individual's personal representative MUST accompany the request.)

Patient Name: _____
Date of Birth: _____

For Health Information Management Office Use Only:
PT MRN: _____
Date Received: _____
Date Completed: _____
30 Day Extension Needed: Yes No

Section C: Response to Amendment Request – Provider Section

☐ Your request for an amendment has been APPROVED; a correction/addendum will be made part of your permanent medical record. A copy of the amended document is attached. Altru will make reasonable attempts to inform and provide the amendment to entities you have identified, or known to Altru, as needing the amendment.

☐ Part of your request has been approved; please see below for more details. A copy of the amended document(s) is attached. Altru will make reasonable attempts to inform and provide the amendment to entities you have identified, or known to Altru, as needing the amendment.

☐ Your request for an amendment has been DENIED; your request has been made a part of your permanent medical record.

Your request was denied for the following reason(s):

☐ Altru Health System did not create the information. Please follow up with _____.
☐ The information is considered complete and accurate.
☐ The information is contained in psychotherapy notes.
☐ The information is compiled in anticipation of or for use in any civil, criminal, or administrative proceeding.
☐ The original author of the information is no longer practicing at Altru Health System.
☐ You did not provide enough information to complete the request.
☐ Other: _____

Additional Information:

_____

_____

_____

Provider Signature: _____ Title: _____ Date: _____

Section D: Patient Options and Contact Information:

If your request is denied:

You may submit a one-page statement of disagreement regarding the denied request. If you do, we will append or link your statement, or an accurate summary, to the medical record(s) you wanted amended for inclusion in future disclosures of those records. We may prepare and send you a rebuttal to your statement of disagreement and, if we do, we will append or link our rebuttal to those same records for inclusion in future disclosures of those records.

Instead of submitting a written statement of disagreement, you may request in writing that your request to amend those records and this denial be appended or linked to those records to be included in future disclosures.

Additional Contact Information:

If you have questions, wish to discuss the denial, review your options, or file a complaint with Altru, please contact Altru's Patient Representatives by phone: 701.780.1909 or 701.780.6430; by Fax: 701.780.1942; or by mail: PO Box 6002, Grand Forks, ND 58206.

You may also file a complaint regarding the denial of this request for amendment with the U.S. Department of Health and Human Services by phone: 800.368.1019; 800.537.7697 (TDD); by Fax: 202.619.3818; by mail: 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; or electronically: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.