

## MEDICAL RECORD AMENDMENT REQUEST FORM

In accordance with HIPAA, as of April 14, 2003, you have the right to request that Nationwide Children's make corrections or amendments to the medical and health information we retain on your child's behalf if you believe something in that information is in error or requires amendment. We are not always required to make the corrections or amendments you request but each request will be reviewed and corrections or amendments made if warranted. You will be notified when your request has been approved or denied, unless you have either not signed the form, provided an address or phone number, or have not provided a reason for the requested correction or change.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address to receive response:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home telephone number \_\_\_\_\_

Please provide as much detail as possible regarding the correction or amendment you seek in your medical information. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, *"my laboratory test results from ABC laboratory of December 5, 2000 show a blood test I never received"* or *"Dr. Jones in your North Street Clinic recorded in my record on December 5, 2000 that I was suffering from weakness in my right leg when in fact the weakness is in my left leg."* In order to review the requested correction, we must be able to locate the record in issue and the exact entries or reports you want corrected.

Please state as precisely as possible how you would like to see the record worded:  
(Attach additional pages if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*CONTINUED ON NEXT PAGE*

If you are aware of anyone else (such as your physician, health care provider, pharmacist, clinic, etc.) who also may have a copy of the record you seek to have corrected, please list those persons or facilities here with as much information as you have available regarding names and addresses. (Attach additional pages if needed.)

Health Care Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

I hereby authorize Nationwide Children's to notify the persons/entities I have listed above that may have a copy of the record I seek to have corrected and to provide them with the amended information. ***Important Note:*** *No amendment request will be processed unless you, the legal guardian has signed this form.*

Your Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_