REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Otsego Memorial Hospital understands that you have a strong interest in making sure that your medical information is accurate.

Otsego Memorial Hospital also understands that you have a right to request that certain of your health information be changed when it is inaccurate or incomplete or becomes outdated for any reason. In order to better maintain accuracy with respect to patient medical information, Otsego Memorial Hospital requires that any patient who would like to have any health information changed or corrected, for any reason, complete this form in total. Please complete all of the information requested on this form and return it to the individual listed below. It is important that you understand that your failure to accurately and completely provide the information requested on this form may prevent Otsego Memorial Hospital from making the requested changes in the medical records or protected health information held by Otsego memorial Hospital. In addition, it is important that you understand that requests for a change in medical records or protected health information held by Otsego Memorial Hospital will not be honored unless the request is made in writing, through the completion of this form. It is also important that you understand that Otsego Memorial Hospital will not make a change if the information contained in your medical record is determined to be complete and accurate. If we do agree to your request, we will put it in writing. If we do not agree to your request, we will notify you of our decision in writing with an explanation for the denial of your request with an explanation of what steps you can take to argue with our decision.

Completed forms should be returned to:

Otsego Memorial Hospital
ATTN: Privacy Officer
825 N. Center
Gaylord, Ml 49735

Please fill in the following information:

1. Patient's birth date _____
2. Patient's name _____
3. Patient's address _____

4. Information you want corrected or amended (e.g., physician notes):

5. Date(s) of information to be amended (e.g., date of office visit, treatment or date of other health care service:

6. Reason you are requesting a change or correction:

7. How is the entry incorrect, incomplete or outdated?

8. What should this entry say to be accurate and complete?

9. Do you know of anyone who might have relied on the information in question (such as your doctor, pharmacist, health plan or other health care provider)?

Yes _____ No _____

If yes, please specify the name(s) and address(es) of the organization or individual(s):

By submitting this form, I hereby request that Otsego Memorial Hospital amend my health information as described above. I understand and acknowledge that Otsego Memorial Hospital is not required to agree to my request.

Patient's signature or signature of legal representative: _____

Today's date: _____

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FOR OTSEGO MEMORIAL HOSPITAL USE ONLY:

Name and title of OMH staff member who received this form:

Date form received:

Date reviewed by Privacy Officer:

Request for amendment has been: _____Accepted _____Denied

If denied, check reason for denial:

- o PHI was not created by this organization
- o PHI is not part of the patient's designated record set
- o PHI is accurate and complete

Staff comments:

Signature of Privacy Officer:

Patient follow-up by: _____
Date of follow-up: _____