



## Patient Requested Amendment Form

(For information contained within the legal medical record of Wellspan Health)

Patient Name (Print Please): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Date of Entry requested to be amended or corrected \_\_\_\_\_

Type of Entry requested to be amended or corrected \_\_\_\_\_

Explain your requested amendment/correction. What do you dispute or what do you believe the entry should state?

---

---

---

---

---

---

---

---

(If additional space is needed, check this box  and attach a separate sheet of paper).

Would you like this amendment, or requested correction sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address below.

---

---

I understand that my request will be considered and **will** become a permanent part of my medical record (regardless if the amendment was granted or denied), including any future authorized requests for release of my Protected Health Information (PHI).

This request will be considered, but may not be granted if Wellspan determines that my protected health information that is subject to this request:

- Was not created by Wellspan or the originator of this PHI is no longer available to act on the requested amendment.
- Is not part of the designated record set maintained by Wellspan Health.
- Would not be available for inspection by me under applicable law dealing with access to PHI.
- Is accurate and complete.

I understand that I will receive a response within 60 days to amend or deny my request.

If WellSpan Health is unable to act on the amendment within 60 days, WellSpan Health may extend the time to act by no more than 30 days, provided that:

- WellSpan Health sends me a written reason for the delay and the date by which WellSpan Health will complete its action on my request: and
- WellSpan Health may have only one extension of 30 days to act on my request.

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Date

----- -- For Wellspan Health Use Only -----

Date Received: \_\_\_\_\_ MRN: \_\_\_\_\_ Acct #: \_\_\_\_\_

Amendment to the Medical Record has been:      Accepted      Denied

If denied, check reason for the denial:      Documentation was not created by WellSpan

Documentation is not part of the patient's  
legal record

Documentation was found to be accurate and  
complete

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Response letter sent to patient: \_\_\_\_\_ (date)

Documentation scanned into EHR: \_\_\_\_\_ (date)

Return this form to:  
Jennifer L. Shorts, RHIA  
York Hospital – Health Information Management  
1001 S. George St  
York, PA 17401