PATIENT’S RIGHT TO REQUEST AMENDMENT OF PROTECTED HEALTH INFORMATION

Patients have the right to request an amendment to their health record. Health Information Services (HIS) will be responsible for assisting patients and accepting patient requests for amendments.

- Patient requests for an amendment of protected health information shall be made in writing to Harvard University Health Services and should clearly identify the information to be amended, as well as the reasons for the amendment. (form attached)
- Submit the form to Harvard University Health Information Services. This can be in person or mailed to the following address:

  Harvard University Health Services
  Health Information Services
  Request for Amendment
  75 Mt Auburn Street 6th Floor
  Cambridge, Ma 02138

- Upon receipt of the completed form an HIS representative will facilitate contacting the provider receiving your request.
- If the provider agrees to the request, the provider will respond with such and make the amendment in your health record. Your request and the response form will be scanned into the record as well. You will be notified of this agreement by letter.
- If the provider does not agree to the request, such will be stated on the physician response form. This form will be made part of your medical record as well as your request and you will be notified of this by letter. You have the right to file a written Statement of Disagreement with Harvard University Health Services setting forth why you disagree with this Denial of Request for Amendment. Details of this process are outlined in the notification letter.

Harvard University Health Services
Health Information Services
(617) 496-1630
REQUEST FOR AMENDMENT/CORRECTION OF PATIENT HEALTH INFORMATION
(Please Print)

Today’s Date:___________________________________________
Harvard University ID (if known): ___________________________
Patient Name:____________________________________________
Date of Birth:____________________________________________
Patient Address:___________________________________________

__________________________________________________________
Telephone #:______________________________________________

After review of my medical record, I do not feel the original documentation accurately reflects my
condition/diagnosis/treatment.

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I request the following amendment/correction be made on my medical record:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I understand the provider may or may not supplement the medical record with an addendum based on my
request, and under no circumstances, is able to alter the original documentation of the medical record. In any
event, this request for an addendum will be made part of my permanent medical record and will be sent as part of
the medical record in response to any authorized requests for my medical information.

Name/address of the organization or individual (such as your health care provider) you would like this sent to:

______________________________________________________________________________
______________________________________________________________________________

______________________________________________________________________________

Signature (Patient or Legal Representative)
PROVIDER RESPONSE TO PATIENTS REQUEST FOR AMENDMENT/CORRECTION OF PERSONAL HEALTH INFORMATION
(Please Print)

Today’s Date:______________________________________________
Harvard University ID (if known): ____________________________
Patient Name:______________________________________________
Date of Birth:______________________________________________

For HUHS use only

Check one of the following - or check both if partially accepted, and explain.

[ ] Accepted. ______________________________________________

____________________________________________________________________

____________________________________________________________________

[ ] Denied. ________________________________________________

____________________________________________________________________

____________________________________________________________________

By:_________________________________________Date:______________