Beaumont

Request to Amend Health Information

You have the right to change, amend, or correct certain parts of your health information that Beaumont Health maintains in a designated record set. In order to ensure accuracy, follow these three steps:

1) Print this form.
2) Fill in the form as completely as you can. Please attach additional sheets of paper if necessary.
3) Send us the form by mail, email or fax. We are committed to responding to your request within 30 days.

Mail to: Beaumont Health
Health Information Management Dept.
3601 West 13 Mile Road
Royal Oak, MI 48073
or Email to: amendrequest@beaumont.org
or Fax to: 248-898-7432

If you have questions, you may contact:
Health Information Management Dept: 248-471-8188
or *my*BeaumontChart support: 248-597-2727

SECTION 1 Patient Information

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth (MM/DD/YY)_____ Social Security Number: _____ ☐ Male ☐ Female

Street Address: _____

City:_____ State:_____ Zip: _____

SECTION 2 About the Health Information

Where did the patient receive medical care that needs to be amended? (Check all that apply)

☐ Beaumont, Dearborn ☐ Beaumont, Trenton ☐ Beaumont, Farmington Hills

☐ Beaumont, Troy ☐ Beaumont, Grosse Pointe ☐ Beaumont, Wayne

☐ Beaumont, Royal Oak ☐ Beaumont, Taylor ☐ Provider Office Visit:_____

When did the patient receive medical care? (MM/DD/YY)_____

How is the health information incorrect, incomplete, or outdated? _____

_____

_____

_____

What do you believe the health information should say to be more accurate or complete?_____

_____

_____

_____

If your health information is amended or updated, please list the names of anyone we should notify?
(Example: the patient's doctor, pharmacist, or health insurance company)

_____

_____

_____

SECTION 3 If someone other than the patient is making this request, please complete this section.

Your Name:_____ Your Phone Number *including area code:*_____

Why is the patient not able to make this request?_____

_____

What is your relationship to the patient?

☐ Adult Child of the patient ☐ Parent

☐ Spouse (husband or wife) ☐ Legal Guardian or Power of Attorney *(Please attach proof of authority)*

☐ Sibling (brother or sister) ☐ Beneficiary of a life insurance policy *(Please attach a copy of the life insurance policy)*

Street Address_____

City:_____ State:_____ Zip: _____

Section 4 You will receive a written response within 30 days from the date we receive your request. Please provide the address where you would like us to respond:

Street Address_____

City:_____ State:_____ Zip: _____

Beaumont Health may not amend, update, or modify health information for the following reasons:

☐ Health Information was not created by Beaumont Health
☐ Health Information is not part of a designated record set
☐ Federal or State law forbids making the Health Information available to the patient or patient's representative
☐ Health Information is accurate and complete, as reviewed by a clinician

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Section 5 Signature of Patient or Patient Representative

Signature_____ Date_____ Time_____

For Beaumont Health Care Use ONLY

Amendment was: ☐ Accepted ☐ Denied Date Received:_____

If denied, check the reason for denial:

☐ PHI was not created by this organization
☐ PHI is not part of the patient's designated record set
☐ Federal law forbids making the PHI in question available to the patient for inspection (e.g., psychotherapy notes)
☐ PHI is accurate and complete

Comments:

_____

_____

_____

Staff Signature_____ Date Reviewed_____

Name and Title of Reviewer _____

Approved by _____