

Beaumont

Request to Amend Health Information

You have the right to request a change, amendment or correction to your medical record or other health information that Beaumont Health maintains in a designated record set.

Return to: Beaumont Health
Attn: Health Information Management
26901 Beaumont Boulevard-2A
Southfield, MI 48033
Fax: 248-597-2848

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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Beaumont, Dearborn | <input type="checkbox"/> Beaumont, Trenton | <input type="checkbox"/> Beaumont, Farmington Hills |
| <input type="checkbox"/> Beaumont, Troy | <input type="checkbox"/> Beaumont, Grosse Pointe | <input type="checkbox"/> Beaumont, Wayne |
| <input type="checkbox"/> Beaumont, Royal Oak | <input type="checkbox"/> Beaumont, Taylor | <input type="checkbox"/> Other: _____ |

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How is the health information incorrect, incomplete, or outdated?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

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 _____