Mail or Fax to:
Partners Healthcare
Chart Correction Unit
399 Revolution Drive, Suite 970
Somerville, MA 02145

telephone: 857-282-9736
email:HIMChartCorrection@Partners.org
fax: 857-282-5904

REQUEST FOR AMENDMENT IN MEDICAL RECORD

Patient name: _____ **Date of request**: _____

Address: _____ **Date of birth:** _____

Contact telephone number: _____

(This section to be completed by patient)
I request the following information to be amended in my medical record:

Date(s) of Entry to be Amended: _____

_____
_____
_____

Reason for request:
_____
_____
_____

If possible, please enclose with this request copies of the specific information to be amended.

If your request is denied:
- **you may submit a statement disagreeing with the denial**
- **you may request that your original amendment request and/or your disagreement with the denial be attached to future disclosures of your personal health information**
- **you may file a complaint with the institution or the U.S. Department of Health and Human Services**

If your request is approved, please list persons that have received your personal health information that need to see the amendment:
Please include name, title and phone number.

_____
_____
_____

I understand that Partners HealthCare System, Inc. ("Partners HealthCare") and/or its affiliated entities has deployed an integrated electronic medical record that is used by Partners HealthCare, its affiliated entities and healthcare providers and other non-Partners HealthCare providers such as Dana-Farber Cancer Institute, Massachusetts Eye and Ear Infirmary and certain community physicians and physician groups. I acknowledge that by signing this form below I consent to and agree that Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated

electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) may receive, and process this amendment request across all records stored within our integrated record system.

Patient/Guardian signature:_____

Relationship:_____Date: _____

The facility has 60 days to respond to the amendment request from the date of receipt. If the facility is unable to act on the request within 60 days, an extension of 30 days may be required. If an extension is required, notification will be provided along with a written explanation.

(This section to be completed by Hospital or Doctor's Office)

Request approved: o **yes** o **no** **Date amendment implemented:** _____

Amendment made:

_____
_____
_____

Request denied: o **yes**

Reason for denial:

___ Protected Health Information (PHI) was not created by this organization
___ Protected Health Information (PHI) is not part of the patient's designated record set
___ Protected Health Information (PHI) is unavailable to the patient for inspection
___ Protected Health Information (PHI) is accurate and complete according to author

___ Comments of Health care practitioner:

_____
_____
_____

Author signature:_____DATE:_____ TIME: _____
