Health Information Management VCU Health System P.O. Box 980679 Richmond, VA 23298	VCU Health VCU Medical Center Richmond, Virginia **Request for Medical Record Amendment**

Patient Name: _____ Date of Birth: _____

Contact Phone #: _____ Medical Record #: _____

Patient Address: _____

_____

The section below MUST be completed in full

Date of entry to be amended: _____

Type of entry to be amended: _____

Explain how the entry is incorrect/ incomplete. What should the entry say to be more accurate or complete?

_____

_____

I authorize the release of the amended information described above to the following parties:
(additional parties may be listed on the back of this page)

Printed Name: _____ Address: _____

_____ _____ _____

Signature of Patient or Personal Representative Date Time

If Personal Representative, attach copy of authorization (patient letter, court order, etc.)

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VCU Health System Use Only

Comments of Healthcare Practitioner (Clinician-author): _____

_____

_____

_____ _____ _____ _____

Signature **Printed Name** Date Time

Date Received: _____

Amendment has been: ☐ Accepted ☐ Denied

If denied, check reason:

- ☐ PHI was not created by this organization
- ☐ PHI is not a part of patient's designated record
- ☐ PHI is not available to the patient for inspection as required by federal law (e.g. psychotherapy notes)
- ☐ PHI is accurate and complete