Request for Correction or Amendment of the Medical Record

Name of Patient _____ Birth Date _____

Address _____ Phone *(home)* _____

City, State, Zip Code _____ Phone *(work)* _____

UW Medicine entity:

- ☐ Harborview Medical Center & Clinics
- ☐ Northwest Hospital & Medical Center & Clinics
- ☐ Valley Medical Center & Clinics
- ☐ University of Washington Medical Center & Clinics
- ☐ UW Medicine Neighborhood Clinics
- ☐ University of Washington Physicians *(billing records only)*
- ☐ University of Washington Sports Medicine Clinic
- ☐ Hall Health Primary Care Center
- ☐ Summit Cardiology

I believe that the medical information made by *(provider name)*:_____

does not correctly show my condition/diagnosis/treatment on the following date(s): _____

and should be corrected.

I understand:

- The original information in my medical record cannot be changed, but a comment, statement, or clarifying note can be added to the record.
- My care provider may not agree with my request to amend my record.
- If my request is denied, my amendment request and the denial will be filed in my medical record, but will only be released if I make that request.

I request the following correction to my medical record *(Please include reason why)*:

If more space is needed, more pages can be attached.

_____

Signature *(Patient or Legally Authorized Surrogate Decision Maker)* _____ Date _____

You may send completed form to:

UW Medicine Health Information Management
325 Ninth Ave. Box 359738
Seattle, WA 98104
Fax: 206.744.9997
Phone: 206.744.9000
Email: himrelease@uw.edu

Northwest Hospital & Medical Center
Mail: 1550 North 115th St., D-129
Seattle, WA 98133
Fax: 206.368.1920
Phone: 206.368.1616

Valley Medical Center
Mail: 400 S 43rd St.
Renton, WA 98055
Fax: 425.656.4026
Phone: 425.251.5159

For Provider Use Only

Provider Please Return To:_____ Box_____ After Review

- ☐ In response to this request, a correction/addendum will be made part of your permanent medical record.
- ☐ This request has been made a part of your permanent medical record; however, your request for amendment has been denied for the following reason(s):

_____

Provider Signature **NPI** **Date** **Time**

For Office Use Only: Sent to Patient: *(Date)*_____ **By** *(Name)* _____

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

REQUEST AMENDMENT OF MED RECORD

UH2078

UH2078 REV NOV 15

WHITE – MEDICAL RECORD
CANARY - PATIENT

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PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

REQUEST AMENDMENT OF MED RECORD

UH2078

UH2078 REV NOV 15

WHITE – MEDICAL RECORD
CANARY - PATIENT