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
- ☐ UW Medical Center & Clinics - Montlake
- ☐ UW Medicine Primary Care
- ☐ UW Physicians *(billing records only)*
- ☐ UW Medical Center & Clinics - Northwest
- ☐ Valley Medical Center & Clinics
- ☐ Hall Health Center

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:

Harborview Medical Center and Clinics
UW Medical Center and Clinics - Montlake
UW Medical Center and Clinics - Northwest
UW Medicine Primary Care Clinics
Hall Health Center
Mail: 325 Ninth Ave. Box 359738
Seattle, WA 98104
Fax: 206.744.9997
Phone: 206.744.9000
Email: uwmedroi@uw.edu

Valley Medical Center and Clinics
Mail: Release of Information
400 S 43rd Street
P.O. Box 50010
Renton, WA 98058
Fax: 425.690.9407
Phone: 425.690.3406
Email: RecordsRequest@valleymed.org

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)* ____________________________

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

REQUEST AMENDMENT OF MED RECORD
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WHITE – MEDICAL RECORD
CANARY – PATIENT

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