Fairbanks
Experts in addictions. Focused on recovery.

Please complete, sign and return this form to: Fairban**ks** HIM Department, 8102 Clearvista Parkway, Indianapolis, IN 46256 or fax to 317 849 7354. **Contact 317 806 7519** with questions.

Section 1: Completed by Patient or Legal Representative

Patient Name:

_____

Last First Middle

Address:

_____

Street City State/Zip Code

Date of Request: _____ **Medical Record #** _____ **Birth Date** _____ **Phone #**_____

I request that the following information be amended/corrected in my medical record: (What should the entry say to be more accurate or complete?) Please specify the specific date(s) of service. If necessary, you may attach one typewritten page of at least a 10- point font to this document.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reason for Request: (please explain why the entry is incorrect or incomplete):

_____
_____
_____

If this amendment/correction should be sent to anyone who already received the original record from us in the past, please provide that person's **Name/Address** here**:**

_____

Healthcare Practitioner/s Comments/Special Instructions: _____

_____
_____

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If your request has been denied, you may:

a. Submit a statement disagreeing with the denial
b. Request that your original amendment/correction request be attached to future disclosures of your protected health information
c. File a complaint with the Fairbanks Privacy Officer, Fairbanks, 8102 Clearvista Parkway, Indianapolis, IN 46256 or with the Secretary of Health and Human Services.

☐ I understand that I will receive a copy of this Form and that my request will be processed in 60 days or I will be informed of the need for an extension of not more than 30 days to process the request.

☐ I understand that even if I do not submit a written statement of disagreement, I may ask for my request for amendment/correction to be included in any disclosure of the information to which the disagreement relates.

Copy of Document in Question Attached: ☐ Yes ☐ No

Patient/Legal Representative Signature: _____ Date: _____

Relationship: _____

Patient Name: _____
MRN: _____

Section II: Completed by Fairbanks Authorized Personnel

Request Approved: □ Yes □ No **Date:** _____
Updated Document(s): □ paper record □ electronic/online record □ both

d.

Section III: Completed by Manager of Health Information Services

Notice of Determination Sent to Patient or Legal Representative: _____ (Date)

Reason(s) for Denial:

□ Fairbanks did not create the information

□ Information is not part of the medical record

□ The responsible healthcare practitioner deemed the information accurate and complete

□ The information contains psychotherapy notes or information completed for use in a civil, criminal or administrative action and where applicable law would prohibit the organization from disclosing the information to the patient because the information would jeopardize the safety of the patient and others.

Authorized Hospital Representative _____ **Title:** _____
Printed: _____
Date: _____