Akron Children's

MEDICAL RECORD AMENDMENT REQUEST FORM

You have the right to request Akron Children's Hospital and its subsidiaries (Children's) to make corrections or amendments to the health information we retain on your/your child's behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request, but each request will be carefully reviewed, and corrections or amendments will be made if warranted. We will notify you when your request has been approved or denied.

Please print clearly to provide the following information:

Patient Name: _____ Date of Birth: _____

Last First M.I.

_____ _____

Name of person requesting change (Patient/Parent/Legal Guardian) Relationship to Patient/ Authority to sign

Address of requester: _____

_____

_____

Contact Phone Number: (_____) _____

Please provide as much detail as possible regarding the correction or amendment you seek in your health information. Be as specific as possible regarding the record type, the location, the date and the problem; for instance, *"My/my child's laboratory test results from ABC laboratory of December 5, 2000 show a blood test that I/my child never received,"* or *"Dr. Jones in your North Street Clinic recorded in my/my child's record on December 5, 2000 that I/my child was suffering from weakness in my/my child's right leg when in fact the weakness was in my/my child's left leg."* In order to review the health information regarding the requested correction, we must have complete information provided to us to be capable of locating the record in question, including the exact entries or reports you would like corrected.

_____

_____

Patient name:_____

_____

_____

Please state as precisely as possible how you would like to see the record worded:

_____

_____

_____

_____

If you are aware of anyone else (such as your/your child's physician, pharmacist, clinic, etc.) who also may have a copy of the record you seek to have corrected, please list those persons or facilities, and include as much information as you have available (names, addresses, phone numbers, etc.):

_____

_____

_____

_____

I hereby authorize Children's to notify the persons/entities I have listed above (that may have a copy of the record I seek to have corrected), and to provide them with the amended information.

_____ _____

Name of Requester (Patient/Parent/Legal Guardian) **(please print)** Relationship to patient/Authorization to sign

_____ _____

Signature of Requester (Patient/Parent/Legal Guardian) Date

Please email completed form to: records@akronchildrens.org or mail to**:**

Akron Childrens Hospital, Attn: Health Information Management, One Perkins Square, Akron, OH 44308.

Note that the amendment request cannot be processed unless you have signed this form.

Please allow up to 30 days from the time the request is received for processing.