Blount Memorial Hospital

Request for An Amendment Of My Medical Record

Health Information Management (HIM)

You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete. The amendment would include the information you believe is in error, and our corrections to that information.

Instructions for requesting an amendment to your medical record

To request an amendment to your medical information, fill out this form and give it to the Health Information Management Department. It will then be given to the HIM Director/Privacy Officer. You may mail or fax the form to us or deliver it in person. Our address is:

Blount Memorial Hospital
Attention: Health Information Management
907 East Lamar Alexander Parkway
Maryville, TN 37804

Fax: 865-977-4779
Hours: Monday through Friday (closed Holidays)
8 am to 4:30 pm
Office location: Ground floor of hospital on Patient Discharge side of hospital

Please fill out all sections of this form.

Patient's last name _____ First Name _____ MI _____

Patient's address _____

City _____ State _____ Zip _____

Home or mobile phone _____ Date of birth _____

Date(s) of service _____

Please mark which entity this request is for:

_____ Hospital
_____ Provider/Physician (ETMG/BMPG)

Explain how the documentation is incorrect or incomplete. Please write exactly what you think the entry should state to be accurate and complete: *(if information provided in request can't be found in the record, or what is described is unclear, the request will most likely be denied) Also be sure to indicate what part of the record has what you feel is incorrect – such as ER note, history and physical, discharge summary, etc.).*

_____

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If your request is accepted and the amendment is made, a copy of the amended information will be sent to anyone who has previously received this information. If there is anyone else you would like to receive this amendment, please write the name(s) and address(es) of the organization(s) or person(s):

Name _____

Address _____

By signing below, I acknowledge and understand:

1. That my request will be considered, but may not be granted if the Blount Memorial Hospital System determines that my protected health information or record that is subject to this request:
   - Was not created by the Blount Memorial Hospital System, unless I provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
   - Is not part of my medical or billing record;
   - Would not be available for me for inspection under applicable law dealing with access to protected health information;
   - or is accurate and complete.
2. I understand that I will receive a response within 60 days to amend or reject my request.
3. If the Blount Memorial Hospital System is unable to act on the amendment within 60 days, Blount Memorial Hospital System may extend the time to act by no more than 30 days, provided that:
   - Blount Memorial Hospital sends me a written reason for the delay and the date by which Blount Memorial Hospital will complete its action on my request; and
   - Blount Memorial Hospital may have only one extension of 30 days to act on my request.
4. If denied, I have the right to file a rebuttal to the decision that will become part of my medical record and will be released to anyone requesting records, along with this amendment request.

_____ _____

Signature of patient or legal representative Date

PATIENTS/REQUESTORS – PLEASE DO NOT WRITE BELOW THIS LINE – INTERNAL USE ONLY

TO BE COMPLETED BY HEALTHCARE PROVIDER/PHYSICIAN

Provider: _____ Accepted _____ Denied _____ Partial Acceptance/Denial

If denied (fully or partially), please check reason for denial:
_____ PHI was not created by Blount Memorial Hospital
_____ PHI is not part of the patient's designated record set
_____ PHI is not available for inspection by Federal Law
_____ PHI is accurate and complete

If accepted, please confirm that an addendum/amendment was made in the record to reflect the change(s):
_____ Addendum/amendment was made to _____ (document type(s); i.e. ER, H&P, etc.)

Comments: _____

_____

_____ _____

Signature of Healthcare Provider/Physician Date

BLOUNT MEMORIAL HOSPITAL HIM/PRIVACY OFFICE INTERNAL USE ONLY

Date received in HIM/Privacy Office: _____ Date sent to Provider: _____ Date returned to HIM/Privacy Office _____

_____ Patient was informed of amendment or denial via letter

_____ _____

Signature/Title of Blount Memorial Hospital Privacy Officer Date