KootenaiHealth

Request for Amendment of Health Information

Please complete the following information:

1. Today's date _____
2. Patient Full Legal Name _____
3. Birth date _____ 4. Patient MRN # _____
5. Patient street address _____

   City _____ State _____ Zip _____
6. Describe the information you want amended (e.g., lab test results, physician notes)

   _____
7. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services)

   _____
8. What is your reason for making this request? _____

   _____
9. How is the entry incorrect or incomplete? _____

   _____
10. **Please attach written amendment.**
11. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

PLEASE MAIL REQUEST TO:
Health Information Department
2003 Kootenai Health Way
Coeur d'Alene, ID 83814

12. If amendment is accepted, do we have your permission to share amendment with individuals who have received this information? _____

Signature of patient/legal representative _____ Date _____

Individual other than patient _____ Relationship _____

Date _____

FOR HEALTHCARE ORGANIZATION USE ONLY

PATIENT NAME _____

Amendment has been: ☐ Accepted ☐ Denied

Signature of Privacy Officer or designee _____ Date _____

- ☐ Patient has <u>not</u> filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.
- ☐ Patient <u>has</u> filed a Statement of Disagreement that **must** be released along with other documentation with any future releases of information.
- ☐ Facility/provider appended written response (rebuttal) and forwarded to patient.
- ☐ Facility/provider did not provide a response/rebuttal.