Outer Cape
HEALTH SERVICES

For Medical Records Use Only
Date Received:
Date sent for review:
Notification of Pt:
Scan to Consents &Contracts

Request for Amendment in Medical Record

Patient Name: _____ **Date of Birth:** _____
Address: _____
_____
Phone: _____

TO BE COMPLETED BY PATIENT:
I request the following information to be amended in my medical record:

_____
_____
_____
_____
_____

The reason I am requesting this change is:

_____
_____
_____
_____
_____

I understand that Outer Cape Health Services has 60 days to review and respond to my request. Outer Cape Health Services may extend this date by 30 days upon notice to me of the delay, the expected time for completion, and the reason for the delay.

If your request is denied:

- **You may submit a statement disagreeing with the denial**
- **You may request that your original amendment request and/or your disagreement with the denial be attached to future disclosures of your personal health information**
- **You may file a complaint with the institution or the U.S. Department of Health and Human Services**

_____
Patient Signature /Personal Representative Date

If Personal Representative, Relationship to Patient _____

TO BE COMPLETED BY PROVIDER'S OFFICE:

Request Approved: Y ☐ N ☐ **Date Amendment implemented:_____**

Amendment Made:

_____
_____
_____
_____

Request Denied: Y ☐

Reason for Denial:

__ Protected Health Information was not created by this organization
__ Protected Health Information is not part of the patients designated record set
__ Protected Health Information is unavailable to the patient for inspection
__ Protected Health Information is accurate and complete according to the author

Comments of Health Care Practitioner/Professional:

_____
_____
_____
_____
_____
_____

Signature and Credentials of Professional Reviewing Request **Date** **Time**

Please submit all requests in writing to:

Outer Cape Health Services
Attn: Medical Records
PO Box 2796
Orleans, MA 02653
Phone: 508-905-2800
Fax: 508-487-6298