Southwestern Vermont Health Care

Health Record Correction/Amendment Form

SVMC ☐ MPD ☐ BAHH ☐ CLR ☐

Patient Name: Patient Birth Date:

Patient Address

Street:

City: State: Zip Code:

Patient Medical Record Number: ____________ Date of entry to be amended: _________________

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete.

Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name and address of the individual or organization.

Individual's Name:

Street Address:

Street:

City: State: Zip Code:

Signature of Patient or Legal Representative Date

************FOR SVHC'S USE ONLY************

Date Amendment Request Received: ____________ Amendment Status: Accepted ☐ Denied ☐

If Amendment Request is denied, check reason for denial:

- ☐ The Protected Health Information was not created by this organization
- ☐ The Protected Health Information is not available to the patient for inspection as required by law (e.g. psychotherapy notes)
- ☐ The Protected Health Information is not part of the patient's health record
- ☐ The Protected Health Information is accurate and complete

Name of Staff Member: __________________ Title: _______________________________

Comments of Healthcare Practitioner:

Signature of Healthcare Practitioner Date

Patient Informed Date: _____________________ Staff Member Initials: ________________

100 Hospital Drive
Bennington, VT 05201

Phone: (802) 447-5323
Fax: (802) 447-5138