REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Telephone Number: _____ Medical Record Number: _____

Description of information to be amended:
Please include the facility, provider, date(s) of service, and a copy of the information to be reviewed. Attach additional pages, if necessary.

_____

_____

_____

_____

If your request is approved, we can provide copies to persons who previously received your health information.
Please include the name, title, and mailing address for each:

_____

_____

_____

I understand that my request will be processed within 60 days of receipt of this request or I will be informed of the need for an extension of not more than 30 days to process the request. I understand that this request for an amendment may be denied. If denied, I have the right to submit a written statement disagreeing with the denial. All information relative to my request for amendment, including this form, will be linked to my records and disclosed to anyone for whom I authorize the disclosure of information relative to the amendment. I further understand that I may file a complaint concerning my request for amendment within 180 days of making the request to Nuvance Health or the Secretary of the U.S. Department of Health and Human Services.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

Please mail, fax, or email your request to:

Danbury Hospital
Attention: Health Information Management
24 Hospital Avenue
Danbury, CT 06810

Fax: (203) 749-9000
Telephone: (203) 739-7218
Email: MedicalRecords@Nuvancehealth.org

For Organization Use Only:

Date Received in HIM: _____/_____/_____

Provider Response:

☐ Agreed. Please see addendum to the medical record dated _____.
☐ Denied. The request is denied for the following reason(s):
- ☐ Information is accurate and complete.
- ☐ Information was not created by this organization.
- ☐ Other _____.

Provider Signature/Title: _____ Date: _____