

Patient Name (Print)		Date of Birth	MRN (Facility)
Address		Home Phone Number	Work Phone Number
After review of my medical record, I do not feel the original documentation is accurate. I wish to add information in the form of an addendum to the medical record.			
Service Date(s):			
I am amending my medical record by adding the following information:			

I understand the care team may or may not supplement the medical record with an addendum based on my request. They, under no circumstance, can alter the original documentation of the medical record. This request for an amendment will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.			
These are the organizations that I want to be informed of the requested amendment:			
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
I understand that by listing the name and addresses of other organizations on this Amendment form, I am asking Reading Hospital to take reasonable steps to disclose the requested amendment to these organizations. I therefore give permission to Reading Hospital to share the amendment with these organizations. In addition, I understand that Reading Hospital may be required to send this amendment to its business associates and other organizations that need to know about this amendment. I give permission to send the requested amendment to those organizations identified by Reading Hospital as needing the amendment.			
Note: If you have additional names, please attach an additional sheet to this page. My signature below signifies that I agree to the above terms.			
Print Patient Name		Date of Birth	
Patient Signature or Authorized Representative		Date	

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

White - Director, Health Information Management
Yellow - Patient