



**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:

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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:

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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 598

Harwich Port, MA 02646

508-905-2800

508-487-6298