Texas Health
Harris Methodist Hospital
SOUTHLAKE

Please fill in the following information completely:

Patient's Name: _____ Date: _____

Birth Date: _____ Medical Record #: _____ Telephone #: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Describe the information you want amended (e.g. physician notes, history & physical etc.)

_____

_____

Date(s) of information you want amended _____

What is your reason for making this request? _____

_____

Do you know of anyone who may have received or relied on the information in question, such as your doctor, health plan or other health care provider? ☐ Yes ☐ No

If yes, please specify the name/organization and their address. _____

_____

I understand that Texas Health Harris Methodist Southlake Hospital is under no circumstance able to alter the original documentation of the medical record. I also understand that if my request to amend is accepted, an addendum will be made part of my permanent medical record and sent to individuals/organizations identified as having relied on the content of my medical record for the provision of medical care. I further understand that if my request is denied, I may submit a written statement of disagreement to the _____ at Texas Health Harris Methodist Southlake Hospital within 30 days. I may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, DC 20201. (This form and any statements of disagreement and rebuttals will become part of the medical record).

Signature of Patient or legal representative: _____ Date: _____

FOR INTERNAL USE ONLY

Amendment has been: ☐ Accepted ☐ Denied(if denied, see reason for denial checked below)

- ☐ Information was not created by Texas Health Harris Methodist Southlake Hospital.
- ☐ Information is not part of Texas Health Harris Methodist Southlake Hospital's designated record set.
- ☐ Information is not available under HIPAA's access provision, e.g., psychotherapy notes.
- ☐ Information is accurate and complete.

The patient or legal representative was provided with a copy of this completed request for amendment.

Individual Processing Request: _____ Date: _____