Marshfield Clinic Health System

Clear Form

Patient Name:	MRN:	DOB:	Sex:

Amendment/Correction of Health Information Request Form

Date of Request: _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Email _____

WHAT NEEDS TO BE AMENDED/CORRECTED AND WHY

Date of entry (month/day/year) _____

Type of Entry _____ **Author of Entry** _____

Explain how your health information is incorrect or incomplete. What should your health information state to be more accurate or complete?

Would you like this information sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual.

Name _____

Address _____

I understand that Marshfield Clinic Health System may or may not amend my medical records with the information in this request, as is allowed under the federal HIPAA Privacy Rule. If the amendment is not accepted, a copy of the amendment form will become part of my permanent health record.

Patient signature _____ Date/Time _____ Printed name _____

Signature of Authorized Person _____ Date/Time _____ Printed name _____

☐ Parent of minor ☐ Court appointed guardian/conservator - include legal documentation

Mail Form to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
ATTN: Health Information Management, HM2

Fax Form to: 715-389-0564

Email Form to: himroiadmrestrevreq@marshfieldclinic.org

For Marshfield Clinic Health System Internal Use Only **Date Received by HIM:** _____ **Date Sent:** _____

Status: ☐ Accepted ☐ Denied

If denied, select reason for denial:

☐ PHI was not created by Marshfield Clinic Health System
☐ PHI is not part of patient's designated record set
☐ PHI is accurate and complete
☐ Other _____

Individual was informed of denial in writing (attach letter of communication)

Staff member signature _____ Date/Time _____ Printed name and Title _____

