Patient Name:_____

Medical Record Number:_____

Date of Birth: _____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

REQUEST TO AMEND
PROTECTED HEALTH INFORMATION

Date of note for review : _____

Provider that wrote the note for review: _____

Please explain what is inaccurately stated in the note for review (Please be specific): _____

_____

_____

_____

What should the information state to be more accurate or complete? _____

_____

_____

_____

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

_____

_____

_____

This authorization is valid for 1 time disclosure upon completion of amendment request and covers only the document(s) that have been amended. By signing this document, you understand that treatment, payment, enrollment of eligibility of benefits may not be conditioned on you signing this form. When information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You will receive a copy of the material to be disclosed.

I understand that the provider may or may not amend my protected health information, based on my request, and under no circumstances is the provider permitted to alter the original health care record. In any event, this request for amendment will be made part of my permanent health care record.

_____ _____

Signature of Patient Date

_____

Relationship, if signed on behalf of the patient

FOR INTERNAL USE ONLY

Date amendment form was received by GL review specialist: _____
Date provider was notified: _____
Additional Comments/Issues: _____

_____

_____

_____