ECMCC's Request for Amendment of Protected Heath Information Form

Name: _____ _____ _____ Date of Birth: _____
Last First MI

Address: _____ City: _____State: _____ Zip: _____

Telephone: _____ (In case we need to contact you with questions about your request.)

Date of Amendment request _____

I am requesting correction/amendment of my medical record relating to my visit to Erie County Medical Center Corporation (ECMCC) on the following date(s) of service:

_____

Please explain below how the documentation is incorrect or incomplete. Please write exactly what you think the entry should state to be accurate and complete. **Attach a copy of the incorrect medical record.**

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If my request is accepted and the amendment is made, a copy of the amended information will be sent to anyone who has previously received this information. I would also like the following organization(s) or person(s) to receive this amendment:

1. Name: _____

   Address: _____

2. Name:_____

   Address: _____

_____ _____

Signature of patient or patient's Legal Representative ***Date***

If you signed as the patient's Legal Representative, please print your name:

_____

I understand that I will receive a written response to my request from Erie County Medical Center Corporation.

I understand that my request may not be granted if ECMCC determines that my health information or medical record that is the subject of this request:

- was not created by ECMCC;
- is not part of my medical or billing record;
- would not be available for me for inspection under applicable law dealing with access to protected health information; or
- is accurate and complete.

Please mail this completed and signed form to:

Erie County Medical Center Corporation
Health Information Management Department & Medical Correspondence
462 Grider Street
Buffalo, NY 14215

Internal use:
Received by HIM (signature) _____
Date: _____ Time:_____