HENRY FORD HEALTH℠

Request for Amendment of the Medical Record

For Health Information Management Office Use Only:

Patient MRN: _____

Date Received: _____

Date Completed: _____

Processed By: _____

Extension Needed: ◯ Yes ◯ No

Decision: ◯ AP ◯ PA ◯ DN

Patient Name: _____

Date of Birth: _____ MRN:_____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____ - _____ Email: _____

You have the right to request that we amend the protected health information (PHI) in your legal medical record maintained by Henry Ford Health. Amendment requests are reviewed and finalized by the care team involved with the requested correction. Requests will be responded to within sixty (60) days and you will be informed in writing if your request was approved, partially approved, or denied.

Instructions: Check the box next to the documentation needing correction. Enter the date of service and reason for correction. Multiple forms can be used if needed. Send a copy of the original documentation along with completed form to the return address below.

Record Type	Name of Report	Date of Service
☐ Lab Result		
☐ Xray/Imaging Report		
☐ Office Note (include Provider Name)		
☐ Diagnosis		
☐ Other		

Reason for Correction (provide as much information as possible, use multiple sheets if needed):

Signature of Patient/Patient Representative _____ Date _____

Relationship to Patient _____ (proof of legal representation is required)

Mail: Henry Ford Health-Health Information Management Department
Attn: Patient Amendments
1414 E Maple Rd
Troy, MI 48083
Email: himpatamendreqefax@hfhs.org **Fax:** 248-607-6946