

Health Information Management 5900 Byron Center Ave. Wyoming, MI 49519 Tel (616) 252-7010 Fax (616) 252-6965 him@umhwest.org

Medical Record Amendment Request

Please complete the following if you wish to amend your protected health information held by University of Michigan Health-West. Please print clearly.

| Date of Request: |
|---|
| Name of Patient: |
| Date of Birth: |
| Medical record number or last four digits of your Social Security Number: |
| Current Address: |
| Phone Number: |
| Date of Service: |
| Specifically describe the reason that the protected health information should be amended. Please write exactly what you think the entry should state to be accurate and complete. |
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| If your request is accepted and the amendment request granted, a copy of the changed information will be sent |
| to anyone who has previously received this information. Is there anyone else you would like to receive this amendment? Please list below: |
| Name: |
| Address: |
| Name: |
| Address |



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| Signature of Patient or Representative: | Date: |
|--|-------|
| INSTRUCTIONS FOR REQUESTING AN AMENDMENT T NOTE: All documentation dealing with your medical record amendmen release of information. | |
| You have a right to request an amendment to your medical reincorrect or incomplete. The amendment would include the corrections to that information. | · |
| FOR MEDICAL INFORMATION: | |
| To request an amendment to your medical information, pleas mail to University of Michigan Health-West Hospital's Heal (Medical Records). | • |
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DEMOGRAPHIC (name, date of birth, address, phone number, etc.) CHANGES:

See the University of Michigan Health-West Hospital webpage: https://uofmhealthwest.org Click on "Contact." Go to "Send A Message" and use the down arrow to view drop down options. Click on "Update My Address." You can also visit any Registration areas as well.

When and how you will hear from us: A letter will be mailed to you within sixty (60) days.