REQUEST FOR AMENDMENT OF
MEDICAL OR BILLING RECORDS

You may tear off this page and retain it for your records.

To submit a request for amendment, please complete, sign and return the attached form to:

Ashley Rose
Privacy Officer
Van Wert County Hospital
1250 South Washington
Van Wert, Ohio 45891

The attached form may be used to request an amendment to a record of your medical care. We are required to amend your medical record, upon request, unless (1) we did not create the information, (2) we do not maintain the information as part of your record, (3) we determine that the information is accurate and complete as currently recorded, or (4) the information is the type that would not be available to you for inspection. Please be aware, however, that under no circumstances will we delete or alter the original documentation in the medical record.

If we did not create the information that you want to have amended, you may submit reasonable evidence that the person or organization that originally created the information at issue is no longer available (i.e., evidence that the doctor who created the information has died, etc.), and we will consider your request.

We usually respond to requests for amendment within 60 days of receiving them. You may expect to receive a response or a notification of delay within that approximate time frame. If we deny your request to amend, you may submit a 1 page/word statement of rebuttal which will be included in all subsequent disclosures of the information at issue. If you choose not to submit a statement, we will include a copy of this request for amendment in all subsequent disclosures of that information, upon receiving your written request to make that inclusion.

For more information about amending a medical record, you may contact our Privacy Officer, at 419-238-8639. Note, however, that requests for amendment must be made in writing and will not be accepted over the phone.

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Today's date _____

Patient's name _____

Medical record # (if known) _____

Birth date _____ Social Security # _____

Address _____

Phone # (H)_____ (W)_____

Describe the information that you would like to be amended (e.g., physician notes, lab test results) _____

_____

_____

On what date(s) was the care that is described in the record provided? _____

_____

What is incorrect about the record? What would you like to change/add to the record? _____

_____

_____

To your knowledge, has anyone received or relied on this information (i.e., your doctor, another health care provider, an insurance company)? If yes, please provide the name(s) and address(es) of those individuals or organizations so that we may inform them of any amendments. _____

_____

_____

Signature _____ Date _____

If you are not the patient, please fill in the following:

Your name _____

Relationship to the patient _____

Address (if different than above) _____

Phone # (if different than above) (H)_____ (W) _____

Signature _____ (Date)_____