Request for Correction/Amendment of Health Information

Glendive Medical Center
www.gmc.org

Health Information Management
(406) 345-3390 Hospital Fax (406) 345-3392 Clinic Fax (406) 345-8908

Date of Request:_____

PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____

Patient Address:_____ Date of Birth:_____

City:_____ State:_____ Zip code:_____

Patient Phone:_____(home) _____ (cell) _____(work)

Date of service to be amended or corrected:_____

Type of service to be amended or corrected (surgery, hospital, clinic, etc.):_____

_____

_____

Please explain how the service is incorrect or incomplete. What should the health information say to be more accurate or complete? (You may attach a copy of the health information with the corrections or amendments noted.)

_____

_____

_____

If this amendment is approved, we would be happy to notify anyone to whom we may have disclosed the information in the past. If you would like us to do so, please specify the name and address of the organization or individual you would like us to notify.

Name:_____ Address:_____

_____ _____

Signature of Patient or Legal Representative ***Date***

Please print, sign and send completed form to:

Glendive Medical Center
Attn: HIM Manager
202 Prospect Drive
Glendive, MT 59330

If you have any questions about this form, please contact us at (406) 345-3390.

*Request received by:*_____ *Date Received:*_____