

# Request for Correction or Amendment of the Medical Record

Name of Patient

Birth Date

Address

Phone (home)

City, State, Zip Code

Phone (work)

## UW Medicine entity:

- |  |   |
|--|---|
| <input type="checkbox"/> Harborview Medical Center & Clinics     | <input type="checkbox"/> UW Medicine Primary Care             |
| <input type="checkbox"/> UW Medical Center & Clinics - Montlake  | <input type="checkbox"/> Husky Health Center                  |
| <input type="checkbox"/> UW Medical Center & Clinics - Northwest | <input type="checkbox"/> UW Physicians (billing records only) |

I believe that the medical information made by (provider name): \_\_\_\_\_ does not correctly show my condition/diagnosis/treatment on the following date(s): \_\_\_\_\_ and should be corrected.

I understand:

- The original information in my medical record cannot be changed, but a comment, statement, or clarifying note can be added to the record.
- My care provider may not agree with my request to amend my record.
- If my request is denied, my amendment request and the denial will be filed in my medical record, but will only be released if I make that request.

I request the following correction to my medical record (Please include reason why):

If more space is needed, more pages can be attached.

Signature (Patient or Legally Authorized Surrogate Decision Maker)

Printed Name

Date

You may send completed form to:

**Harborview Medical Center and Clinics**  
**UW Medical Center and Clinics - Montlake**  
**UW Medical Center and Clinics - Northwest**  
**UW Medicine Primary Care Clinics**  
**Husky Health Center**

Mail: Enterprise Records and Health Information  
Box 354914  
1959 N.E. Pacific St.  
Seattle, WA 98195  
Fax: 206.520.3195  
Phone: 206.744.9010, Option #3  
Email: erhiccp@uw.edu

## For Provider Use Only

Provider Please Return To: \_\_\_\_\_ Box \_\_\_\_\_ After Review

- In response to this request, a correction/addendum will be made part of your permanent medical record.
- This request has been made a part of your permanent medical record; however, your request for amendment has been denied for the following reason(s): \_\_\_\_\_

Provider Signature

For Office Use Only: Sent to Patient: (Date) \_\_\_\_\_ By (Name) \_\_\_\_\_ NPI \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PLACE PATIENT LABEL HERE

UW Medicine  
REQUEST CORRECTION AMENDMENT OF MEDICAL RECORD  
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WHITE – MEDICAL RECORD  
CANARY – PATIENT