

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:

- ☐ Harborview Medical Center & Clinics
☐ UW Medical Center & Clinics - Montlake
☐ UW Medicine Primary Care
☐ UW Physicians (billing records only)

- ☐ UW Medical Center & Clinics - Northwest
☐ Valley Medical Center & Clinics
☐ Hall Health Center

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)

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

Hall 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

Valley Medical Center and Clinics

Mail: Release of Information

400 S 43rd Street

P.O. Box 50010

Renton, WA 98058

Fax: 425.690.9407

Phone: 425.690.3406

Email: RecordsRequest@valleymed.org

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

NPI

Date

Time

For Office Use Only: Sent to Patient: (Date) _____ By (Name) _____

PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center

UW Medicine Primary Care – Valley Medical Center – UW Physicians

REQUEST AMENDMENT OF MED RECORD

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WHITE – MEDICAL RECORD
CANARY – PATIENT