AURORA MENTAL HEALTH CENTER

REQUEST FOR AMENDMENT TO THE MEDICAL RECORD

I am requesting an amendment to the medical record of:

_____ _____ _____
Client Name (please print) Social Security Number Date of Birth

_____
Requester's Name, if other than the client (please print)

_____
Requester's Street Address

_____ _____
Requester's City / State / Zip Code Requester's Phone

The part of the record that I would like to amend is: (Attach an additional page, if necessary.) _____

_____

_____

_____

I believe this amendment is necessary because: (Attach an additional page, if necessary.) _____

_____

_____

_____

The Center will act on this request no later than 60 days after receipt. If the Center is unable to act on this request within 60 days, I will be provided a written statement of the reason for the delay and the date by which the Center will complete action. This extension will be no more than 30 days and will occur only one time.

IF MY REQUEST IS ACCEPTED, I understand that I must identify other persons who maintain health information about me who need to be informed of the amendment. I agree to have the Center release information contained in the amendment to these persons.

IF MY REQUEST IS DENIED, I understand that I will be provided a written explanation for the denial. I will also be provided an explanation of the appeal process in the event that I do not agree with the basis for the denial.

_____ _____
Client, Legal Guardian, or Other Legal Representative Signature Authority to act for the Client

_____
Date

_____ _____
Staff Signature Date

For Center Use Only

Client ID: _____

Request Granted/Denied: _____ Notice to Requester: _____
Date Date