***Southwestern Vermont Medical Center***
*100 Hospital Drive*
*Bennington, VT 05201*

**Health Record Correction/Amendment Form**

☐ SVMC
☐ SVMC Medical Practice
☐ CLR

You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete. The amendment would include the information you believe in error, and your corrections to that information.

Patient Name: ______________________________ Date of Birth: __________

Street: ______________________________

City: ____________________ State: ______ Zip Code: __________

Phone Number where you can be reached: (___) __________.

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete. Please include a copy of the document that you believe requires an amendment:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

If your request is accepted and the appropriate amendment is made, a copy of the amended information will be sent to anyone who has previously received this information. If you need this amendment sent to anyone, please indicate the name and address of the individual or organization. Additional names and addresses can be written on the reverse side of this document.

Individual's Name: ______________________________

Street: ______________________________

City: ____________________ State: ______ Zip Code: __________

To request an amendment to your medical information, fill out this form and a copy of the incorrect document and mail or fax to the Director of Health Information Services Department at:

Southwestern Vermont Medical Center
Attention: Director of Health Information Services (HIS)
100 Hospital Drive
Bennington, VT 05201
Phone: (802) 447–5336
Fax: (802) 440–4076

______________________________ __________ __________
Signature of Patient or Legal Representative Date Time

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Individual's Name: ______________________

Street: ______________________

City: ______________________ State: ________ Zip Code: ________

Individual's Name: ______________________

Street: ______________________

City: ______________________ State: ________ Zip Code: ________

**** FOR SVHC'S USE ONLY ****

Medical Record Number: ______________________

Date Amendment Request Received: ____________ Amendment Status: ☐ Accepted ☐ Denied

If Amendment request is denied, check reason for denial:

- ☐ The Protected Health Information was not created by this organization.
- ☐ The Protected Health Information is not available to the patient for inspection required by law (e.g. psychotherapy notes).
- ☐ The Protected Health Information is not part of the patient's health record.
- ☐ The Protected Health Information is accurate and complete.

Name of Staff Member: ______________________ Title: ______________________

Comments of Healthcare Practitioner:

______________________________________________

______________________________________________

______________________________ ____________ ____________
Signature of Healthcare Practitioner: Date Time

Date of Amendment: ____________

Patient Informed Date: ____________ Staff Member's Initials: ____________

*Original to be retained as part of the permanent medical record*