Dartmouth Health
Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Health Record Correction/Amendment Form

SVMC Hospital
SVMC Medical Practice
Other _____

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: _____

Phone Number: _____ Fax Number (if known): _____

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

Southwestern Vermont Medical Center
Attention: Health Information Services (HIS)
100 Hospital Drive
Bennington, VT 05201
Phone: (802) 447–5212
Fax: (802) 447–5138

Patient or Personal Representative | Relationship to patient | Date | Time

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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.

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