

Request for Amendment to Health Information

Patient Name: _____ D.O.B: _____

Address: _____

Phone Number (H): _____ (W) _____

Medical Record Number: _____ E-mail: _____

Upon review of my medical information, I am requesting that Health Information Management (aka: Medical Records) review my record from service date(s): _____ and consider amending the record as noted below. I understand that my request may not be granted. **I further understand that per Cameron Memorial Community Hospital retention policy, the original document cannot be altered or deleted unless the entry date is 30 years or older. Any change requested on an earlier dated entry will be made in the form of an addendum.** I also understand that this form will become a permanent part of my medical record, whether or not the request is granted, and that I have the right to submit a Statement of Disagreement should my request be denied. I understand that HIM must act on my request for an amendment no later than 60 days after receipt of my request.

I request the following information be corrected in my medical record:

If this request is granted, I request a copy of this completed form be sent to:

Name of Organization: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient or Legal Representative Signature: _____

Relationship to Patient: _____ Date: _____ Time: _____

Witness Signature: _____ If Utilized, Interpreter Name/ID# _____

PARTY RESPONSIBLE FOR RESPONSE: Clinical Provider HIM Legal Department _____

In response to your request, an addendum has been made to your permanent medical record.

Upon review of your record, your request for amendment is denied for the following reason:

Responding Party Signature: _____ Date: _____ Time: _____

HIM Professional Signature: _____ Date: _____ Time: _____

All entries must be dated and timed



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Revised Date: 02/26/2026

Form Name: Request for Amendment to Health Information
Form Owner: HIM

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Place Patient Label or
Patient Name _____
DOB _____
MRN _____