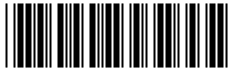

Saint Luke's Health System

Request for Amendment

Patient Name:______________________________ Birth Date:__________

Address:______________________________

City:__________ State: __________ Zip: __________ Phone Number: (   ) ______-______

Medical Record Number:______________________(if known)

1. Information Requested to be changed:

Date of Visit/Service	Information Type (Office visit, ER note, Procedure Note, etc.)	Provider Name & Facility (if known)

2. Reason for change (amendment) request? Is this information inaccurate, missing information, etc.? ** attach a copy of record being disputed, if possible

☐ Inaccurate Information

☐ Diagnosis ☐ Medication ☐ Allergies ☐ Social History ☐ Medical/Surgical History ☐ Other (specify below)

☐ Missing Information

☐ Diagnosis ☐ Medication ☐ Allergies ☐ Social History ☐ Medical/Surgical History ☐ Other (specify below)

____

____

3. What change to the documentation do you believe would improve accuracy of your record?

____

____

Signature:______________________________Date:__________Time:__________
(Patient or Legal Representative)

Relationship to patient if someone other than patient:______________________________

Please Return Form to: Any Medical Record Department or the SLHS Privacy Office at 901 E. 104th St., Mailstop 3000-S, Kansas City, MO 64131 or via email at privacy@saintlukeskc.org

While it is unlikely, there is a possibility that unsecure email could be intercepted and read by other parties besides the person to whom it is addressed. By sending your request by email, you are agreeing to accept these risks.

FOR PRIVACY OFFICE USE ONLY

Request Received By:______________________ Title:__________ Date:__________

Request Assigned To:______________________ Title:__________ Date:__________

☐ Accepted
☐ Accepted in part with the following changes:______________________________
☐ Denied (Reason For Denial):
- ☐ PHI was not created by this organization
- ☐ PHI is accurate and complete
- ☐ PHI is not available to the patient for inspection (as required by the federal law)
- ☐ PHI is not part of the patient's designated record set
- ☐ Other ______________________________

Signature: Healthcare Provider/Privacy staff:______________________Date:__________Time:__________

Privacy Staff send to HIM to File in Medical Record