Berks Community Health Center

Please complete, sign and return this form, with your original signature to:
Medical Records Clerk
Berks Community Health Center
645 Penn Street, Suite 301
Reading, PA 19601

Instructions

You have the right to request that Berks Community Health Center (BCHC) amend or correct the medical information contained in your official medical and financial records if you believe the information is incomplete or inaccurate. BCHC will respond to your request within 60 days of receipt of the request. If BCHC needs more than 60 days to respond to your request, we may take one extension of up to 30 days, and we will notify you by letter that we are taking the extension. To make a request, please complete all the information on this page.

Please Remember: The law does not permit us to change or delete the information in your medical record.
If an amendment is granted, the agreed-upon amendment will be added to your medical record.
If your request is denied, you have the right to:

- Submit a written statement to BCHC disagreeing with the denial.
- Request that your original amendment/correction request and denial be attached to future disclosures of your protected health information.
- File a complaint with the BCHC Privacy Officer, 645 Penn Street, Reading, PA 19601; or with the Secretary of Health & Human Services.

Request for Amendment/Correction to Medical Record

Date of Request:___/____/_____ **Patient's Date of Birth:**_____/_____/_____

Patient Name: _____
First Name Middle Last Name

Address: _____
Street

_____ Telephone # _____
City State Zip

I request that the following information be amended/corrected in my medical record: *(TIP: Tell us – what should it say to be more accurate or complete?) Please tell us the name of the document or the date(s) of service where the information is that you believe is wrong. Need more room? You may attach a printed or typed page to this form.*

_____

_____

_____

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_____

_____

Reason for Request: (Please explain why the entry is incorrect or incomplete):

_____

_____

_____

_____

_____

_____

_____

OVER ➔

Berks Community Health Center

Is a copy of the document or information attached? ❑ Yes ❑ No

Would you like this amendment/correction sent to anyone to whom we may have sent the information in the past? If so, please give us the name(s) and address(es): (Attach another sheet if needed.)
Name/Address:

_____

_____

_____

_____

_____

_____

_____

_____

Please check both of the boxes below, and sign at the bottom.

❑ I understand that I will receive a copy of the this Form and that my request will be processed in 60 days or I will be informed of the need for an extension of not more than 30 days to process the request.

❑ I understand that if I do not submit a written statement of disagreement, I may ask for this request for amendment/correction to be included in any disclosure of the information which I disagree with.

Patient/Legal Representative Signature:_____

Date:___/_____/_____Relationship to patient: ❑ Self ❑ Parent/Legal Guardian ❑ Power of Attorney (attach)

THIS SECTION TO BE COMPLETED BY BCHC PERSONNEL ONLY

❑ Request Approved ❑ Request Denied Date: _____/_____/_____

Updated Document(s):

_____

Reason(s) for Denial:

- ❑ BCHC did not create the information.
- ❑ Information is not a part of the designated record set in the medical record.
- ❑ The responsible healthcare practitioner deems the information accurate and complete.
- ❑ The information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative action and where applicable law would prohibit the organization from disclosing the information to the patient because the information would jeopardize the safety of the patient and/or others.
- ❑ CLIA.
- ❑ Other _____

❑ Notice of Determination sent to Patient or Legal Representative on (Date) ___/___/ ___ (copy attached)

Authorized Signature: _____ Title: _____

Print Name: _____ Date: ____/____/____