Keystone Health Center

HIM Department
111 Chambers Hill Drive, Suite 200
Chambersburg, PA 17201
Phone (717) 709-7960 Fax (717) 217-1937
Email: khc-him@keystonehealth.org

Medical/Dental Record Amendment Request form

Patient Name:_____

Address:_____

_____
City State Zip

DOB:_____

DOS: _____Provider_____

You have the right to request that Keystone Health Center amend or correct the medical/dental information contained in your designated record if you believe the information is incomplete or inaccurate. Keystone Health Center will respond to your request within the 60 days of receipt of the request. Please note: In requesting an amendment to your medical/dental record, you understand the Keystone Provider may or may not supplement your record with an addendum based on your request. You understand your Keystone Provider is not allowed to alter the original documentation in your record. You understand, your request for amendment will be made a permanent part of your medical/dental record and will be sent with any future authorized requests for information.

You understand if your request is denied, you have the opportunity to provide a statement of disagreement to the Site Director/Manager. If a statement of disagreement is submitted, you understand the denial and statement of disagreement regarding the denial will become part of your medical/dental record. In addition, you understand you may take additional complaints to the Site Director/Manager or Secretary of the Department of Health and Human Services.

Please describe the information you would like amended:

_____

_____

Date(s) of the information you would like amended:_____

Reason for requesting amendment:_____

_____

_____

_____

What would you like for the amended information to say:_____

_____

_____

_____

Do you know of anyone to whom we may have disclosed this information in the past? If so, please provide the name(s) and address(es):_____

_____

_____

_____
Patient Signature

_____
Date

_____
Legal Guardian or Patient Representative Signature

_____
Date

_____
Describe Relationship to Patient if other than self

This Section for Internal Use Only

Date request received:_____ Deadline to grant/deny request:_____

Originator of records indicated by this request notified: By:_____ Date:_____
Staff Signature

Extension Requested: □ No □ YES If yes, reason:_____

Extension deadline date:_____

Amendment to records: □ Granted □ Denied By:_____ Date:_____

Reason for Denial: ___Record is accurate and complete
___Record was created by another provider
___Record is Privileged and unavailable for inspection
___Record is not part of the "designated record set"
___Other_____

Amendment to: □ Paper □ Electronic □ Both

Letter mailed to patient: Date:_____

Records appended or linked to the amendment: By:_____ Date:_____
Staff Signature

Other entities notified of amendment:

_____ Date:_____

_____ Date: _____

_____ Date: _____

If denied, was statement of disagreement received? □ No □ Yes Date:_____

KHC rebuttal prepared: □ No □ Yes Date mailed:_____

Site Director/Manager:_____Date:_____

Physician Signature:_____ Date:_____