Hudson Hospital & Clinic

HealthPartners®

Request for Correction/Amendment of Health Information

Hudson Hospital and Clinic
Release of Information
405 Stageline Road
Hudson, WI 54016
Tel 715-531-6230
Fax 715-531-6231

Internal Use Only

MRN _____

Completed by _____

Date _____

Patient name (first, middle initial, last)			
Date of birth	Phone number		
Address	City	State	Zip code
Medical record number (optional)	Date of entry to be amended		

Please explain in detail, how the entry is incorrect or incomplete _____

What should the entry say to be more accurate or complete? _____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past?

☐ Yes ☐ No

If yes, name of the organization or individual			
Address	City	State	Zip code

Signature of patient or legal representative	Printed name	Date

For Hudson - Health Information Management Use Only

Staff initials _____

☐ Routed to Clinician ☐ Called patient if needed

Date received _____

☐ Received from Clinician Date response letter sent to patient _____

Amendment has been:

☐ **Accepted**

Documentations have been corrected in:

☐ EPIC

☐ Paper chart

☐ **Denied**

Reason for denial:

☐ Information was not created by this organization

☐ Information is not part of the patient's designated record set

☐ Information is not available to the patient for inspection

☐ Information is accurate and complete as required by the federal law (e.g., psychotherapy notes)

Comments of Healthcare Provider _____

Signature of Healthcare Provider	Printed name/credentials (MD, etc.)	Date