REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Central Virginia Community Services, Lynchburg, Virginia

CLIENT NAME: _____ DOB:_____

CLIENT ID (MEDICAL RECORD) NUMBER: _____

ADDRESS:_____

TELEPHONE NUMBER: (H) _____ (W)_____

After review of my medical record, I do not feel the original documentation made by:_____

_____

accurately reflects my condition/ treatment / diagnosis on the following service dates: _____

_____ and should be supplemented with clarifying information in the form of an amendment to my medical record.

I understand Central Virginia Community Services may or may not supplement my medical record with an amendment based on my request, and, under no circumstances is Central Virginia Community Services able to alter the original documentation of the medical record. In any event, this request for an amendment will be made part of my permanent medical record and will be sent as part of my medical record in response to any authorized requests for my health care information.

I REQUEST THE FOLLOWING AMENDMENT BE MADE IN MY MEDICAL RECORD:

_____

_____

_____

_____

_____

_____

_____ _____

SIGNATURE (Client or Legal Representative) **DATE**

AGENCY RESPONSE

___ In response to your request, an amendment will be made part of your permanent medical record.

___ Your request has been made a part of your permanent medical record, however, your request has been denied for the following reason(s): _____

_____

_____

_____

_____ _____

SIGNATURE DATE

Original: Medical Record Yellow Copy: Client

2/18/03