1035 116TH AVE NE, BELLEVUE, WA 98004 overlakehospital.org

OVERLAKE MEDICAL CENTER & CLINICS
MultiCare

Dear Valued Overlake Patient,

At Overlake we strive to maintain accurate and complete health records for our patients. Please fill out the Health Record Amendment form if there is incomplete or inaccurate information in your health record.

To complete please provide:

- Your name first and last as it appears on your health record
- Date of Birth
- Current mailing address (your notice of approval or denial will be sent here)
- Date of visit needing amending
- Explain in bullet points or short sentences what information is incomplete or inaccurate. Include specific information that will make your health record more accurate and complete.
- You or your personal representative must thoroughly complete the Amendment form or it will be considered invalid.
- If you would like to request a copy of your medical record, please contact the Release of Information Staff at 425-688-5643.

Once we receive your Health Record Amendment Form we will submit it to the provider that entered the incomplete or inaccurate information. After the provider has reviewed the request and the record you will receive a letter notifying you of the acceptance or denial of your request. If the provider agrees with you they will make the appropriate changes to your record. If the provider disagrees with your request your record will remain unchanged. However, if your request is denied you will have the opportunity to rebut the provider's decision, instructions for this are included in the denial letter that you will receive.

Thank you,

Health Information Management

RETURN COMPLETED AMENDMENT REQUESTTO:

Overlake Hospital HIM Department ATTN: Data Integrity Team
1035 116Th Ave NE, Medical Office Tower Suite LL175
Bellevue WA 98004

Health Record Amendment Form

PLEASE USE BLACK INK ONLY

Note: All sections (A-D) must be legible and completed in full. Submission of incomplete forms may delay processing.

SECTION A – Patient information:

Patient Name: _____ Birth Date: _____

Patient Address: _____ Phone: _____

SECTION B – Exact description of health information you are requesting to be amended:

Date(s) of your visit/service: _____

Write exactly which information is incorrect or incomplete. Include provider name and date/time of entry.	**Write exactly what you think the information should say.**

SECTION C: Signature and Date:

_____

Print Name of Patient or Legal Representative

_____ _____

Signature of Patient or Legal Representative **Date**

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Patient Record #_____

Health Record Amendment Form

Form A1131 *1002*

PLACE PATIENT LABEL HERE