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.
- List individuals or organizations that may have received a copy of the incorrect record that need a corrected copy.
- You or your personal representative must thoroughly complete the Amendment form or it will be considered invalid.

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 REQUEST TO:

Overlake Hospital HIM Department ATTN: Data Integrity Team
1135 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 - Should the amended information be sent to anyone else? Please indicate the name and address of the individual or organization:

____ ____

Name Address

____ ____

Name Address

SECTION D: Signature and Date:

____ __________________

Signature of Patient or Legal Representative **Date**

Patient Record #_________________