ALBANY MED Health System

Health Information Management

Patient Amendment Request Form

NOTE: *Sections A, B & C of this form must be fully completed with a signature and date (please print clearly). Submission of an incomplete form may delay processing of your request.*

Section A | Patient Information

Patient Name *(First, Middle, Last)*		
Date of Birth *(mm/dd/yyyy)*	Medical Record Number	
Current Mailing Address		Apartment/Unit#
City	State	ZIP
Contact Phone #	Email address *(if any)*	

Section B | Description of health information you are requesting to be amended:

NOTE: *If you are signed up for MyChart, Albany Med Health System's secure online patient portal, you will be able to easily fill out the information below. If you would like to sign up to ease filling out the information below, you can sign up* **at mychart.albanymed.org**.

Date of Service:

Facility Name: ☐ Albany Medical Center ☐ Columbia Memorial Health ☐ Glens Falls Hospital ☐ Saratoga Hospital

Information Type:
(Diagnosis, office visit, discharge summary etc.)

Provider Name:

Location Name/Type:
(Hospital, specialty, or primary care, etc.)

1. What is the reason for this amendment request?

2. What does the current information say that you believe is inaccurate?

3. What change to the documentation do you believe would improve the accuracy of your information?

Section C | Understanding your right to request an amendment of your health information:

I understand that I have the right to request an amendment to my health information maintained in the designated record set at Albany Med Health System (AMHS). I understand that AMHS is not always required to make the amendments I have requests; however, my request for amendment will be carefully reviewed and amendments will be made when warranted. I understand that I will receive a written response regarding my request to amend within 60 days. If AMHS denies my request (in whole or in part), I will receive an explanation of why it was denied and what my options are.

Signature of Patient/Patient's Personal Representative	**Date**

Please send this form and any attachments to:

MAIL Albany Med Health System
Health Information Management
43 New Scotland Ave., MC 67
Albany, NY 12208-3555

FAX 518-580-2463

EMAIL amhsmedicalrecordrequest@amc.edu