Request to Exercise Privacy Rights – Amendment of Medical Record

Date ______________

Patient name ____

Date of birth ____________________________ Phone number ____

Street address ____

City ________________________________ State ________________ Zip Code _______________

Submit this completed form to the Health Information Management department by emailing it to MedicalRecordAmendment@novanthealth.org or by faxing it to 336-277-6858. Contact the Novant Health Privacy Office at 704-384-9829 if you have any questions.

I request that Novant Health change/amend [Please check the following that apply]:

- ☐ Medical Record
  - ☐ Medical Center – Name: ____
  - ☐ Clinic – Name: ____
- ☐ Billing record

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results) (You may attach supporting documentation if applicable)____

   ____

2. Explain how the documentation is incorrect or incomplete. Please write exactly what you think the entry should state to be accurate and complete:

   ____

   ____

   ____

3. List the date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services)

   ____

4. I would like for Novant Health to respond to my request by (choose one option):

   ☐ Email: ___________________________________ ☐ Mail ☐ Fax: ________________________ ☐ MyChart

I understand that:

- Novant Health may deny this request as permitted under federal law,
- If Novant Health denies this request, they will notify the requestor in writing the reason for the denial and what action can be taken if the requester disagrees with Novant Health's decision.
- Novant Health will notify the requestor of its decision to accept or deny this request within sixty (60) days of receiving the request. If Novant Health is unable to respond to the request within this time frame, it may extend the applicable deadline for up to an additional thirty (30) days by notifying the requestor in writing.

____ ______________ __________

Patient signature Date Time

____ ______________ __________

Legal Representative/relationship Date Time

For Office Use Only

☐ Request granted ☐ Request granted in part (see attached letter)

☐ Request denied (see attached letter)

Leadership signature-title ____ Date:__________ Time:__________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted ____ ☐ Interpreter refused

(Name/number of person/services chosen/used)

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803190 R 07/20/20201

Patient Name: ______________________________

DOB: ______________

Or label

Name / MR # / Label