College Park Family Care Center
REQUEST TO AMEND HEALTH CARE INFORMATION

GUIDELINES

1. You have the right to amend your health care information, if you feel it is inaccurate or incomplete.
2. To request an amendment to your health care information, please complete the following form and submit the completed form to us either by:
   Fax to**: (913) 338-1311**
   Email to**:** PMMW.CP.HIM@HCAHealthcare.com
   M**ai**l to: ATTN: CMR-College Park Family Care Center
   11725 W. 112th Suite, 202
   Overland Park, KS 66210
3. We will review the request and may decide to deny the amendment. Reasons why we would deny the amendment include, but are not limited to, the following: (a) we feel it is false or misleading or (b) we feel that it could cause harm to you or to someone else.
4. When you refer to a document, or documents, in your health record, you will need to describe each document individually so it can be identified.
5. If we accept your amendment, it will be attached as a permanent document in your health record. When you make a reference to specific document, or documents, in your record, a note will be appended to each such document referencing your amendment. If you do not identify specific documents or state "all, then your amendment will be added as a separate document into your record and no notes will be appended to other documents.
6. If we make the change and you agree, we will send it to anyone we know has received the information in the past. We will also send the amendment to anyone you identify.
7. We will review your request and respond within 60 days of receiving your request.

I hereby request that health care information maintained on the following patient be amended:

Patient Name: ________________________________ Patient Birthdate: ________________

The following documents are the ones I wish to reflect the amended information: *(if necessary, please attach additional pages)*

DATE OF INFORMATION	DESCRIBE THE INFORMATION (MEDICAL RECORD, LAB RESULTS, ETC.)

I would like my information amended to include the following: *(if necessary, please attach additional pages & documentation)*

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The information should be amended for the following reasons: *(incorrect, incomplete, etc.) attach additional pages if necessary*

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This information is requested by:

______________________________________ ______________________________________
Printed name of Patient or Patient's Representative Relationship to Patient

______________________________________ ______________________________________
Signature of Patient or Patient's Representative Date

FOR OFFICE USE ONLY

Amendment has been: ☐ Approved ☐ Denied-Letter sent ☐ Records Amended

If denied the reason is: ☐ Health Care Information was not created by this organization
☐ Health Care Information in question is not available for review due to federal or state law
☐ Health Care Information is complete and accurate

Comments: ____

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Signature of staff who reviewed request *Date*