VIRGINIA HOSPITAL CENTER

Request for Amendment of a Medical Record

Virginia Hospital Center – Arlington
Health Information Management
1701 North George mason Drive
Arlington, VA 22205
Phone: 703-558-6116 FAX: 703-558-6979

Medical Record Number _____

To Be Completed by Patient

Patient Name: _____ Birth Date: _____
Address: _____ Phone: (H) _____
_____ (W) _____

I do not feel the original documentation made by Dr. _____ accurately reflects my condition/diagnosis/treatment on the following service date(s): _____ and should be supplemented with clarifying information in the form of an addendum to the medical record.

I understand the physician may or may not supplement the medical record with an addendum based on my request, and under no circumstances is able to alter the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

I understand that I must attach name and address for a copy of amended records to be sent to anyone to whom the information was previously disclosed.

I REQUEST THE FOLLOWING CORRECTION/SUPPLEMENTATION BE MADE TO MY MEDICAL RECORD:

_____
_____
_____
_____
_____
_____

_____ _____
Signature (Patient or Legal Representative) Date

To Be Completed by Physician

☐ In response to your request, a correction/addendum will be made part of your permanent medical record.

☐ Your request has been made a part of your permanent medical record; however, your request has been denied for the following reasons:

_____
_____
_____
_____

_____ _____
Physician Signature Date

To be Completed by HIM Department

Date Received _____ Date Patient Notified – Request was ____ Accepted _____Denied
Patient requested copies to be sent _____ No _____ Yes (see attached request)
Name of Staff Member: _____ Title: _____

Original – Medical Record Yellow Copy – Physician Pink Copy - Patient