Dear Valued Patient,

Snoqualmie Valley Hospital commits to maintain an accurate and complete health records for our patients. Please fill out the 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,

Medical Records Department

AMENDMENT OF PROTECTED HEALTH INFORMATION

<u>SECTION A</u>: Patient to complete the following information

Date:

Patient Name:

Date of Birth:

Mailing Address:

REQUEST:

I hereby request that the Snoqualmie Valley Hospital amend the following in my Designated Record Set **(check all that apply)**:

_____My Medical Records _____ My Business Office Files

Date(s) of information to be amended (i.e., date of visit, treatment, or other health care services)

____

____

The information is incorrect or incomplete in the following manner:

____

____

I request this amendment for the following reason(s):

____

____

The information should be amended as follows:

____

____

I understand that the Snoqualmie Valley Hospital may or may not supplement my record with an addendum based on my request. I also understand that the Snoqualmie Valley Hospital is not able to alter the original documentation in a record under any circumstances. Regardless whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information.

____

Signature of Patient or Personal Representative Date

____

Print Name

____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Please mail form to:

Snoqualmie Valley Hospital

Attn: Medical Records

9801 Frontier Ave SE

Snoqualmie WA 98065