218 East Road, Hampstead, NH 03841

Request for Amendment of Health Information

Please print, complete and mail to: "Attn Health Information Dept" or fax to 603-329-9460

Date:_____MR #_____
Name:_____DOB:_____
Address:_____
_____
Home Phone:_____Work Phone:_____
Cell Phone: _____ (please circle best # to reach you)

I understand that Hampstead Hospital may or may not supplement my medical record with an addendum based on my request and under no circumstances, is able to alter the original documentation of the medical record. This request for an amendment may or may not be made part of my medical record and will be sent to individuals/organizations identified below as having relied on the content of my medical record.

Describe the information you would like to have amended (i.e., lab test results, physician notes):
_____
_____
_____
What is your reason for making this request? _____
_____
_____
_____

What would you like to add/change to the record?_____
_____
_____

Date(s) of information to be amended (e.g., date of hospitalization, treatment or other service):
_____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other health care provider? __yes ___no
If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).
_____
_____

_____ _____
Patient/Guardian Signature Date

I understand that I have the right to submit a written statement of disagreement and the basis for the disagreement. I understand that I have the right to request that this Request for Amendment and the denial become a permanent part of the medical record.
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