HAMPSTEAD HOSPITAL
218 East Road, Hampstead, NH 03841
Ph: 603-329-5311 Fax: 603-329-9460

Request for Amendment of Health Information

Please print, complete, and mail to the Health Information Department at the above address or fax to 603-329-9460.

Date: _____ **Medical Record #:** _____

Patient: _____ **Date of Birth:** _____
Last First Middle
Address: _____ **Telephone:** _____

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 results, physician notes): _____
_____
_____
_____
_____

What is your reason for making this request? _____
_____
_____
_____

What would you like to add or change to the medical record? _____
_____
_____
_____
_____

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

Do you know of anyone who may have received or relied on the information in question (i.e. physician, pharmacist or other health care provider)? _____ Yes _____ No

If yes, please specify the name(s) and address(es) of the individual(s) or organization(s).
_____
_____
_____
_____

If my request is denied, 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, if applicable, the denial, become a permanent part of the medical record.

____/____ /____ _____ _____
Date Patient/Guardian Signature Print Name

Eff: 2003, R&R 9/13, 12/19