KAISER PERMANENTE®

REQUEST TO CORRECT OR AMEND KAISER PERMANENTE HEALTH INFORMATION NORTHERN CALIFORNIA REGION

MR #: _____

Name: _____

Date of Birth: _____

Email: _____

IMPRINT AREA

I have identified the following health care information in my health record to be incorrect or incomplete and request to have the information corrected or amended.

Date of record: _____ Provider Name/Location: _____

Please indicate what information is incorrect or incomplete and what the information should include to be complete and accurate. This request for correction applies to my ☐ Hospital Record or my ☐ Medical Office Record

I understand that Kaiser Permanente will review my request for correction or amendment of records and respond within sixty (60) days of receipt, except in unusual circumstances.

I understand that an amendment or correction is made in a manner that retains the original content but clearly indicates the amended content.

By checking this box ☐ I request to have an addendum (attached) added to my medical record. I understand that in doing so, this addendum will be disclosed with all future requests for my record.

By checking this box ☐ I request that a copy of any corrected/amended be provided to me and to the persons/entities listed below that I know to have previously received the information and could have relied upon it.

Date	Signature of patient / authorized representative	Relationship to patient if not patient

Address (Street, City, State, Zip, Email). Final determination will be returned by secure email if email provided.

Name/Contact of persons/entities to send amended information: _____

THIS SECTION IS TO BE COMPLETED BY A KAISER PERMANENTE PROVIDER OR REPRESENTATIVE AND RETURNED TO THE PATIENT AT THE ADDRESS ABOVE <u>WITHIN SIXTY (60) DAYS</u>.

Correction / Amendment has been: ☐ Accepted ☐ Denied

Description of correction/amendment: _____

If denied, check reason for denial:

- ☐ The existing health information is accurate and complete.
- ☐ This health information was not created by this organization.
- ☐ This request was not part of the patient's health care records.
- ☐ The record no longer exists or cannot be found.

I have reviewed this request for correction/amendment and responded with the decision indicated above.

Provider Name (printed)	Provider Signature	Date

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I request that this addendum be made a part of my medical record. I understand that in doing so, this addendum will be disclosed with all future requests for my medical record.

Patient Signature: _____ Date: _____

Printed Name: _____

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If your request is approved/accepted by your provider and you have checked the box requesting a copy of the corrected/amended information be provided to you, a copy will be emailed or mailed to your address(s) on file within 60 days of completion of the corrections.

The completed form with your provider determination will be emailed or mailed to your address(s) on file within 60 days.

If you have checked the asking for your written addendum to be attached to your record, and you have supplied that written addendum with this form, the addendum will be attached to your record within 10 business days of completed review by the provider. The addendum and request for amendment will be included in all future relevant disclosure of your information.

If you provided names and contact information for persons/entities that you wish to receive a copy of your corrected information, we will send that information within 10 business days of the final determination by your provider if the amendment is approved.

If your provider has denied your request because the existing information is a) accurate and complete, b) the information was not completed by this organization, c) the information no longer exists, cannot be found or d) is not part of your healthcare records, and you disagree with the decision, you have the following options available:

1. Request a reconsideration and appeal of the denial, and/or
2. Complete a written statement of disagreement to be placed in your medical record.

Both options can be initiated by calling us at: 1-800-464-4000.

Kaiser Permanente respects your right to file a complaint. If you have any questions, concerns or wish to file a complaint with us, please contact us at 1-800-464-4000.

You also have the right to contact the Department of Health and Human Services through the Office for Civil Rights at 1-800-368-1019.