Nuvance Health

Patient Request to Amend Health Information

Name of Patient:_____ Date of Birth:_____ Medical Record #:_____

Date of Service:_____ Telephone # (Home/Work): _____

Patient Address: _____

_____

I request the opportunity to amend my personal health information maintained by Danbury Hospital, New Milford and Norwalk Hospitals as described below.

Please fill out the information requested below completely.

Please clearly describe the information you would like to have amended and how you would like the information to be amended: (Attach additional pages if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I believe the amendment is necessary for the following reasons: _____

_____

Would you like this amendment sent to anyone else to whom we may have disclosed information in the past?

☐ Yes ☐ No If yes, please specify the name and address organization or individual:

_____

_____

I understand that Danbury, New Milford and Norwalk Hospitals may deny my request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the hospital may deny my request if the information:

1. was not created by the hospital, unless I provide reasonable evidence that the person or entity that created the information is no longer available to act on the requested amendment;
2. is not part of my clinical or billing records maintained by or for the hospital or used to make decisions about me;
3. is not part of the information that I have a right to inspect and copy; or
4. is already accurate and complete as determined by the hospital.

_____ _____

Signature of Patient or *Patient's Authorized Representative* Date

If signed by the *Patient's Representative*, please print name and describe relationship to patient:

_____ _____

Name Relationship to Patient