Request to Exercise Privacy Rights – Amendment of Medical Record

Date _____

Patient name _____

Date of birth _____ Phone number _____

Street address _____

City _____ State _____ Zip Code _____

This form lets you exercise the privacy rights that you have under federal law. **You have the right to ask us to change information that you think is wrong in your medical record.**

Instructions:

Please explain in detail what information you think is wrong in your medical record. Please include the date(s) of service and which Novant Health location is involved. You may attach additional information to this form.

Contact Novant Health Privacy Office at 704-384-9829 if you have any questions.

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_____ _____ _____ _____

Patient signature Date/time Legal Representative/relationship Date/time

For Office Use Only

☐ Request granted ☐ Request granted in part (see attached letter)

☐ Request denied (see attached letter)

Leadership signature-title _____ Date/time _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter refused

(Name/number of person/services chosen/used)

NOVANT HEALTH

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803190 R 9/22/2016

Patient Name: _____

DOB: _____

Or label

Name / MR # / Label