ISLAND HOSPITAL

Request for Island Hospital to Correct or Amend Health Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____

Patient Mailing Address: _____

☐ **I request a change to my records.**
Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record: _____**

_____

_____

_____

_____
Patient or legally authorized individual signature Date

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

We will review your request and respond within 10 business days of receiving your request. A copy of your request will be added to your record.

We will send changes to:
- ☐ Anyone you identify, and
- ☐ Anyone who received the information in the past and who needs to know about the change.

Please submit to Island Hospital, Attn: Medical Records Director, 1211 24th St., Anacortes, WA 98221.

To be completed by the practice/health care facility

Date Received:_____ Correction/Amendment has been: ☐ Accepted ☐ Denied

If Denied, *please see Request for Correction/Amendment Denial Form for details and further instructions.*

☐ The review of this request for correction/amendment has been delayed. Your request will be processed by the following date: _____ (no later than 21 days after the request).

_____
Name of reviewing department or position Date