CHARTERCARE

REQUEST FOR AMENDMENT IN THE MEDICAL RECORD

Roger Williams Medical Center ☐ **Our Lady of Fatima Hospital** ☐

825 Chalkstone Blvd Providence, RI 02908 200 High Service Ave North Providence, RI 02904

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

Address: _____ Phone Number: _____

(This section to be completed by patient) Date of Request: _____

I request the following information to be amended in my medical record:

Reason for Request:

Patient / Guardian Signature: _____ Relationship: _____

(This section to be completed by the hospital)

Request approved: Yes ☐ No ☐ Date of Amendment: _____

Amendment made:

Request Denied: Yes ☐ No ☐

Reason for Denial:

Notification of amendment change / request sent to patient / designee: _____

Signature: _____ Date: _____

If your request is denied:

- You may submit a statement disagreeing with the denial
- You may request that your original amendment request and denial be attached to future disclosures
- You may contact the hospital's Privacy Officer