Aurora Mental Health & Recovery

REQUEST FOR AMENDMENT TO THE MEDICAL RECORD

I am requesting an amendment to the medical record of:

_____ _____ ____/____/_____
Client Name (please print) Social Security # Date of Birth

_____
Requestor's Name, if other than the client (please print)

_____
Requestor's Street Address

_____ _____
Requestor's City / State / Zip Code Requestor's Phone

The part of the record that I would like to amend is: (Attach an additional page, if necessary.)_____
_____
_____
_____

I believe this amendment is necessary because: (Attach an additional page, if necessary.)
_____
_____
_____
_____

AMHR will act on this request no later than 60 days after receipt. If AMHR is unable to act on this request within 60 days, I will be provided a written statement of the reason for the delay and the date by which AMHR will complete action. This extension will be no more than 30 days and will occur only one time.

IF MY REQUEST IS ACCEPTED, I understand that I must identify other persons who maintain health information about me who need to be informed of the amendment. I agree to have AMHR release information contained in the amendment to these persons.

IF MY REQUEST IS DENIED, I understand that I will be provided a written explanation for the denial. I will also be provided an explanation of the appeal process in the event that I do not agree with the basis for the denial.

_____ _____ _____
Client, Guardian, or Legal Representative Signature Authority to act for the Client Date

_____ _____
Staff Signature Date

For Center Use Only

Client ID: _____

Request Granted/Denied: _____ Notice to Requester: _____
Date Date

Revised 06/2024