STANFORD HOSPITAL and CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL
STANFORD, CALIFORNIA 94305

Return Address:

Health Information Management Services
300 Pasteur Drive, HC006, MC 5202
Stanford, CA 94305-5202

CORE • REQUEST FOR AN ADDENDUM OR CORRECTION

SECTION A: PATIENT INFORMATION

Patient Name:	Date of Birth:	Medical Record Number (If Known):
Mailing Address:		Phone Number:

SECTION B: WHAT INFORMATION IS INCORRECT OR INCOMPLETE?

Specify Name of the Document (Op Report, H&P, Progress Notes, etc)	Date of the Document	Who is the author of the document?	Which Information is Incorrect or Incomplete?

SECTION C: REQUEST TO ADD AN ADDENDUM (for Adult Patients)

If you are an adult patient of the Hospital and you believe that an item or statement in your medical record is incorrect or incomplete, you have the right to provide the Hospital with a written addendum to your record, not to exceed 250 words. If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incorrect or incomplete. To add an addendum to your record, please provide us with a statement in the space below regarding the item or statement that you believe to be incorrect or incomplete. (You may attach additional sheets as necessary.)

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SECTION D: REQUEST TO ADD A CORRECTION (AMENDMENT)

If you believe that the protected health information the Hospital has on file about is incorrect or incomplete, you have the right to ask us to correct the information in your records. To request a correction to your protected health information, please complete this Section D of this form.

Please tell us what changes you would like to make to the information you described in Section B, above:

Please tell us why you want this change. You must give a reason:

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide.

If we decide to change the health information as you requested, we will send the change to any person you identify who received the information before it was changed. Please tell us if there are any such persons who need the changed information:

❑ No. Initial: _____
❑ Yes. Please list the persons' names and addresses:

Name	Address

We will also send the amendment to other persons that we know received the information before it was changed if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?
❑ No. Initial: _____
❑ Yes. Initial: _____

We do not have to change your protected health information if:
1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.

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4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

Signature of Patient or Personal Representative _____ Date _____

If representative, give relationship: _____

Please send request to the address below. For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.stanfordhospital.com or www.lpch.org or by sending a written request to SHC/LPCH - Health Information Management Services, 300 Pasteur Drive, Room HC006, MC 5202, Stanford, CA 94305-5202.