GroupHealth®

Request to Correct or Amend Group Health Cooperative Health Information

Name _____

Member I.D. Number _____

Date of Birth _____

I have identified the following health care information in my health record to be incorrect or incomplete and request to have the information corrected or amended.

Date of record: _____ Provider (if known): _____

Please indicate what information is incorrect or incomplete and what the information should include to be more complete and accurate: _____

_____

_____

I understand that Group Health will review my request for correction or amendment of records and respond within ten days of receipt, except in unusual circumstances. If unusual circumstances exist, Group Health will notify me of any delay and respond within twenty-one days of receiving my request.

I understand that an amendment or correction is made in a manner that retains the original content but clearly indicates the amended content.

I understand that if Group Health makes the requested change(s), a copy of the corrected/amended health information will be sent to me or to any persons known to have previously received the information and could rely upon it:

Date	Signature of patient or patient's authorized representative	Relationship to patient if not patient

Address (Street, City, State, Zip)

THIS SECTION IS TO BE COMPLETED BY GROUP HEALTH STAFF UPON RECEIPT OF THE REQUEST.

Date request received by Group Health**:** _____

THIS SECTION IS TO BE COMPLETED BY A GROUP HEALTH PROVIDER OR REPRESENTATIVE AND RETURNED TO THE RELEASE OF INFORMATION DEPARTMENT (CSB-1) WITHIN THREE BUSINESS DAYS.

Date reviewed by: _____

Correction / Amendment has been: ☐ Accepted ☐ Denied

Description of correction/amendment: _____

_____

_____

If denied, check reason for denial:

☐ The existing health information is accurate and complete.
☐ This health information was not created by this organization.
☐ This request was not part of the patient's health care records.
☐ The record no longer exists or cannot be found.

I have reviewed this request for correction/amendment and responded with the decision indicated above.

Provider Name (printed)	Provider Signature	Date