NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

MEDICAL RECORD AMENDMENT REQUEST FORM

INSTRUCTIONS:

1. This form must be completed to request that Nationwide Children's amend health information in its records.
2. You must provide all of the information requested on this form in order for us to respond to your request.
3. Once you have completed this form, you may give it to any office staff member who will transmit it to the Privacy Officer via confidential fax at 614-355-3181.
4. No later than 60 days after you turn in this completed form, you will receive a written response to your request, via email or regular mail, from Nationwide Children's Hospital.

PLEASE PRINT:

Full Patient Name _____

Patient Date of Birth _____

Your Name _____

I am the Patient's (check one): ___Mother ___Father ___Stepmother ___Stepfather

___Legal Guardian___Power of Attorney ____Grandparent___Other (specify) _____

___Foster Parent (patient is in the custody of_____)

Your Mailing Address

Street/Apartment Number _____

City/State _____

Zip Code _____

Your Telephone Number (____) _____

Your email Address _____@_____

Please tell us **what** health information you would like us to amend. (Use additional pages if necessary.) Be as specific as possible regarding the record type, where the record was generated, and the date. (For example, "I would like to amend my child's ABC Laboratory test results dated December 5, 2010" or "all records reflecting my child's blood type as O positive")

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Please tell us **why** you want the health information amended. (Use additional pages if necessary.) Be as specific as possible about the reason. (For example, "My child never received a blood test from ABC Laboratory" or "my child's blood type is O negative")

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By signing this form:

I affirm that I am the patient's representative and have the authority to authorize who may access this patient's health information and to review and/or request changes to this patient's health information.

SIGNATURE_____

DATE_____