NeighborHealth
10 Gove Street
East Boston, MA 02128

Tel 617-569-5800
www.neighborhealth.com

## Request for Amendment/Correction to Medical Record

**Patient Name:** _____

**Address:** _____

**Date of Request:** ____ / ____ / ____ **Medical Record #:** _____ **Birth Date:** ____ / ____ / ____

*Below, please specify the information to be amended/corrected (including the date(s) of service), what you believe is incorrect/missing from the information, and what the record should say in order to be more accurate or complete.*

_____
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**If your request is denied, you may:**

- **Submit a statement disagreeing with the denial. This statement will be attached to your medical record and sent along with any release of the record; OR**
- **Request that your original amendment/correction request and our denial be attached to future disclosures of your record**

**You may also file a complaint with the NeighborHealth Privacy Officer, 300 Ocean Avenue, Revere, MA 02151 or MRD@neighborhealth.com.**

Would you like this amendment/correction sent to anyone to whom we may have sent your medical record in the past? If so, please specify name(s) and address(es) for each recipient:

_____
_____
_____
_____

☐I understand that I will receive a copy of this Form and that my request will be processed within 60 days or I will be informed of the need for an extension of not more than 30 days to process the request.

☐I understand that if I do not submit a written statement of disagreement, I may ask for a copy of this request for amendment/correction to be included in any disclosure of the information to which the amendment/correction request pertains.

**Signature of Patient or Authorized Representative:** _____
**Date:** ____ / _____ / _____ **Relationship to Patient:** _____