For Staff Use Only:
PT EPIC MRN: ________________
Date Received: ________________
Date Completed: ________________
Extension Needed: ☐ Yes ☐ No
Outcome: ☐ Approved ☐ Denied

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

Patient Name: ________________________________

Date of Birth: ________________________________

Address: ________________________________

City, State, Zip: ________________________________

Phone Number: ________________________________

Submit Your Request to:
Aspirus Health
Attn: Health Information Management – Pt Amendment
333 Pine Ridge Blvd
Wausau, WI 54401
Email: Aspirushealthinformation@aspirus.org

Section A: To the Individual - Please read the following and complete the information requested.

I understand that I have the right to request that we amend the protected health information in your legal medical record that Aspirus, Inc maintains. I further understand that this document may become a component of my permanent medical record and per 45 CFR § 164.526, Aspirus has 60 days to act upon this request after receiving it but may extend the time by no more than 30 days by written request.
We may decline your request if:

- The information is not part of Aspirus's legal medical record;
- We did not create the information;
- We believe the information is complete and accurate;
- The information is contained in psychotherapy notes;
- The information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding;
- The original author of the documentation is no longer practicing at Aspirus;
- The information is not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263(a)).

Date of entry to be amended: ____________________ **Type of entry to be amended**: __________________________

Please explain how the entry is incorrect or incomplete and what the entry should say to become more accurate and complete:

____
____
____
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____
____

Section B: To the Individual- Please read the following and complete the information requested.
Release of Information – If approved
If you would like a copy of your amended medical record sent to any previous or new recipients you can make this request by: completing a Release of Information form found at aspirus.org under the "Medical Records" section, completing a request in your MyAspirus portal, or by contacting the Release of Information Department at (715) 847-2180 or aspirushealthinformation@aspirus.org.

Signature of Patient/Representative: ____ Date: _____/_____/_______
If signed by person other than the patient, please print name and state relationship.
Print Name: ____ Relationship: ________________________