Northern Light Health

MEDICAL RECORD AMENDMENT REQUEST

Page 1 of 3

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

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<th>Phone</th>
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<tbody>
<tr>
<td>Acadia Healthcare</td>
<td>(207) 973-6100</td>
<td>(207) 973-6822</td>
<td>(207) 861-3150</td>
<td>(207) 861-3158</td>
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<tr>
<td>Acadia Hospital</td>
<td>(207) 973-6100</td>
<td>(207) 973-6822</td>
<td>(207) 973-6900</td>
<td>(207) 973-6999</td>
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<tr>
<td>A.R. Gould Hospital</td>
<td>(207) 768-4175</td>
<td>(207) 768-4060</td>
<td>(207) 664-5454</td>
<td>(207) 664-5398</td>
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<tr>
<td>Beacon Health</td>
<td>(207) 973-5692</td>
<td>(207) 989-1096</td>
<td>(207) 564-4270</td>
<td>(207) 564-4360</td>
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<tr>
<td>Blue Hill Hospital</td>
<td>(207) 374-3458</td>
<td>(207) 374-3971</td>
<td>(207) 275-2940</td>
<td>(207) 973-9487</td>
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<tr>
<td>C. A. Dean Hospital</td>
<td>(207) 695-5225</td>
<td>(207) 695-2254</td>
<td>(207) 879-3373</td>
<td>(207) 822-2469</td>
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<tr>
<td>Continuing Care Lakewood</td>
<td>(207) 873-5125</td>
<td>(207) 861-9967</td>
<td>Pharmacy</td>
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<tr>
<td>Eastern Maine Medical Center</td>
<td>(207) 973-7873</td>
<td>(207) 973-7867</td>
<td>(207) 487-4026</td>
<td>(207) 487-3204</td>
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<tr>
<td>Home Care &amp; Hospice</td>
<td>(800) 757-3326</td>
<td>(207) 400-8891</td>
<td>Sebasticook Valley Hospital</td>
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Nondiscrimination Statement: Northern Light Health and its affiliates (Northern Light Health) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. Northern Light Health does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 797 Wilson St., Suite 4, Brewer, ME 04412, 1-866-769-8363 (telephone), 1-207-989-1420 (fax), or at nondiscrimination@northernlight.org (email). If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.

MEDICAL RECORD AMENDMENT REQUEST

Please fill out this form to request that a patient’s Northern Light Health medical record be modified.

Please note, all requests to amend will be reviewed within sixty (60) days of receipt of the request.

Northern Light Health will respond in writing within this timeframe to notify you of the following:

- Additional time is needed to review your request. Northern Light Health will respond in writing with a decision within thirty (30) days of the extension notice.
- The request to amend has been accepted and the requested change(s) has been made.
- The request to amend has been denied and the requested change(s) has not been made.
- The request to amend has been accepted/denied in part.
Requestor’s Name: ___________________________ Date: __________ Time: ________

(Patient or Authorized Representative)

Patient Name: ___________________________________ Patient Date of Birth: __________

Patient Medical Record Number: _______________ Dates of Service: ______________________

Please identify the incorrect or incomplete information in the medical record. Explain how the information is incorrect or incomplete and indicate what changes you are requesting.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

If Northern Light Health accepts your request to amend, is there someone to whom you wish the amended records to be sent? If so, please indicate the name and address of the individual or organization.

__________________________________________________________________________________

By signing below, you are indicating that you understand that Northern Light Health, under certain circumstances, may deny your request for amendment. Further, you understand that if Northern Light Health denies your request for an amendment, you will be provided a written response outlining the basis for the denial.

__________________________________________________________________________________

Signature of Requester Date Time

Date Reviewed: 11/17/2021 Date Revised: 6/1/2020