|  |  |  |  |
| --- | --- | --- | --- |
| Click or tap here to enter text. |  | **Acadia Healthcare** | **Inland Hospital** |
|  | **Acadia Hospital** | **Laboratory** |
|  | **A.R. Gould Hospital** | **Maine Coast Hospital** |
|  | **Blue Hill Hospital** | **Mayo Hospital** |
|  | **C. A. Dean Hospital** | **Medical Transport** |
|  | **Continuing Care Lakewood** | **Mercy Hospital** |
|  | **Eastern Maine Medical Center** | **Sebasticook Valley Hospital** |
|  | **Home Care & Hospice** | **Work Health** |
|  |  |  |

**MEDICAL RECORD AMENDMENT REQUEST**

**Patient Identification**

Page 1 of 2

**PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW**

|  |  |  |
| --- | --- | --- |
| **Entity** | **Phone** | **Fax** |
| Northern Light Health Hospitals | (207) 973-7873 | (207) 973-7867 |
| Home Care & Hospice | (800) 757-3326 | (207) 400-8891 |
| Laboratory | (207) 973-6900 | (207) 973-6999 |
| Continuing Care Lakewood | (207) 873-5125 | (207) 861-9967 |
| Medical Transport | (207) 275-2940 | (207) 973-9487 |
| Work Health | 1-844-975-4584 | (207) 973-4930 |

**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:

Page 2 of 2

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.

Click or tap here to enter text.

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.

Click or tap here to enter text.

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: 04/09/2024 Date Revised: 04/09/2024