SSMHealth
Dean Medical Group

Request to Amend Health Information

To submit a Request to Amend Health Information, please complete this form and send it to **SSM Health Dean Medical Group – Health Information, P.O. Box 259840, Madison, WI 53725**. SSM Health Dean Medical Group will send you a written response within 60 days of the date this form is received.

Patient Name_____ Date of Birth_____

Address_____

Disclaimer: In order for your request to be processed, this form must be filled out completely and specific details regarding your request must be provided. Your request must be limited to this form and one typewritten page or two handwritten pages if needed. If you require a copy of your medical records in order to help complete this form, please contact 877-510-1873.

1. What is the specific documentation you would like changed? (I.e. what are the specific words or phrases that are incorrect or what specific information is missing?)

   _____

   _____

   _____

   _____

2. Who is the specific author of the documentation? (If unknown, describe where you saw the information: MyChart, After Visit Summary, etc.)

   _____

3. What is the specific date of the documentation? (If unknown, describe where you saw the information: MyChart, After Visit Summary, etc.)

   _____

4. In your opinion, how should the documentation be amended in order for it to be accurate or complete?

   _____

   _____

   _____

   _____

I understand that once submitted, this request will become a permanent part of my medical record and that SSM Health Dean Medical Group will release this form and SSM Health Dean Medical Group's response letter with any future disclosures of the information that is the subject of this request.

_____ _____

Signature of Patient or Patient's Legal Representative Date

If this Request is signed by a representative on behalf of a patient, please complete the following:

_____ _____

Representative's Name (Please Print) **Relationship to patient**

FOR INTERNAL USE ONLY
Date Received:
Initials:

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