Medical Record Number

Patient Name

Please send request to:
Stanford Health Care Tri-Valley
Health Information Management Services
1111 E. Stanley Blvd., Building D
Livermore, CA 94550
Fax: (925) 373-4126

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE TRI-VALLEY
5555 W. LAS POSITAS BLVD.
PLEASANTON, CALIFORNIA 94588

ADMIN • REQUEST FOR AN ADDENDUM OR CORRECTION

Patient Name:	Date of Birth:	Medical Record Number (If known):
Mailing Address:		Phone Number:

If you believe that the protected health information the Hospital has on file about you is incorrect or incomplete, you have the right to ask us to correct the information in your records.

Please specify the document(s) with incorrect or incomplete information:

Name of the Document (Operative Report, History & Physical, Progress Notes, etc.)	Date of the Document	Author of the Document

Please check one (1) box to indicate what type of change you would like to make to your personal health information:

☐ **Addendum** – you are requesting to include an additional statement into your medical record. Please provide your statement below in 250 words or less (you may attach additional sheets as necessary).

☐ **Amendment (Correction)** – you are requesting the authoring clinician to make changes to your personal health information. Please explain below what changes you would like made and why you want this change (a reason must be given).

If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incorrect or incomplete. We must inform you within 60 days of receipt if we will change your protected health information as you requested, or inform you that we need more time (up to 30 additional days) to review your request.

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example: the doctor who originally created the information has died).
2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want to change.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

If we decide to change the health information as you requested, please let us know if there is anyone else who you would like informed:

☐ Yes, Initial: _____ ☐ No, Initial: _____

If yes, please indicate who you would like to be informed:

Name	**Address**

We will also send the amendment to other persons that we know received the information before it was changed if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

☐ Yes, Initial: _____ ☐ No, Initial: _____

DATE _____ TIME _____ SIGNATURE (Patient, or Properly Designated Representative) _____ INITIALS _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____ MEDICAL RECORD NUMBER _____

Please send this request to the address at the top of this form.

For more information about your privacy rights, see the “Notice of Privacy Practices” available on our website at https://stanfordhealthcare.org/tri-valley or by sending a written request to the address at the top of this form.