The Children's Hospital of Philadelphia®

MR-110
Rev. 7/10

REQUEST TO ADDEND/CORRECT RECORDS

LAST NAME ____ FIRST NAME ____

MR# ____ DOB ____

PLACE PATIENT LABEL HERE OR COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

A patient or his/her legal guardian has the right to request a change to information he/she believes is inaccurate or incomplete in a patient record maintained by The Children's Hospital of Philadelphia.

Please complete and return this form to:

The Children's Hospital of Philadelphia
Health Information Management Department
34th and Civic Center Boulevard
Philadelphia, PA 19104

Patient Name: ____________________
Patient Date of Birth: ____________________
Address: ____________________
____
____
____

Date of service request pertains to: ____________________

Name of physician or department request pertains to: ____________________

I request the following change be made:

____
____
____
____

I request the change because:

____
____
____

Signature ____________________ Print Name ____________________ Date ____________

Relationship to Patient: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other: ____________

To be completed by Children's Hospital Staff

Request received and forwarded by: ____________________ Print Name ____________ Title ____________ Date

Referred to: ____________________ Print Name of Division/Physician ____________ Date

Please forward a second copy to the Office of Compliance and Privacy at the above address