

Name \_\_\_\_\_

Member I.D. Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Request to Correct or Amend  
Kaiser Permanente Health Information**

I have identified the following health care information in my health record to be incorrect or incomplete and request to have the information corrected or amended.

Date of record: \_\_\_\_\_ Provider (if known): \_\_\_\_\_

Please indicate what information is incorrect or incomplete and what the information should include to be more complete and accurate: \_\_\_\_\_

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I understand that Kaiser Permanente will review my request for correction or amendment of records and respond within ten days of receipt, except in unusual circumstances. If unusual circumstances exist, Kaiser Permanente will notify me of any delay and respond within twenty-one days of receiving my request.

I understand that an amendment or correction is made in a manner that retains the original content but clearly indicates the amended content.

I understand that if Kaiser Permanente makes the requested change(s), a copy of the corrected/amended health information will be sent to me or to any persons known to have previously received the information and could rely upon it:

Date \_\_\_\_\_ Signature of patient or patient's authorized representative \_\_\_\_\_ Relationship to patient if not patient \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_

**THIS SECTION IS TO BE COMPLETED BY KAISER PERMANENTE STAFF UPON RECEIPT OF THE REQUEST.**

Date request received by Kaiser Permanente: \_\_\_\_\_

**THIS SECTION IS TO BE COMPLETED BY A KAISER PERMANENTE PROVIDER OR REPRESENTATIVE AND RETURNED TO THE RELEASE OF INFORMATION DEPARTMENT (RCG-D1N-02) WITHIN THREE BUSINESS DAYS.**

Date reviewed by: \_\_\_\_\_

**Correction / Amendment has been:**  Accepted  Denied

Description of correction/amendment: \_\_\_\_\_

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If denied, check reason for denial:

- The existing health information is accurate and complete.
- This health information was not created by this organization.
- This request was not part of the patient's health care records.
- The record no longer exists or cannot be found.

I have reviewed this request for correction/amendment and responded with the decision indicated above.

Provider Name (printed) \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_