Mail or fax completed form to:

Mason City Clinic
ATTN: Medical Records Manager
250 South Crescent Drive
Mason City, IA 50401
Fax: 641-494-5403

Request To Amend or Correct Health Information

Name of requesting individual: _____ Date_____

Address_____

Telephone: _____Social Security #:_____ Date of Birth: _____

Describe the amendment or correction that you would like to make._____

_____

_____

Identify any other persons or entities you believe have received your health information and need to be notified of the amendment/correction that you are requesting.

_____

Information about your Amendment/Correct Rights

- We will not process your request for an amendment/correction of your health information if it is not made in writing on this form or does not tell us why you think the amendment is appropriate.
- We will act on your request within 60 days (or 90 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied.
- We may deny your request if you ask us to amend information that:
  - ✓ Was not created by Mason City Clinic, unless the person who created the information is no longer available to make the amendment;
  - ✓ Is not part of the information Mason City Clinic keeps about you;
  - ✓ Is not part of the information that you would be allowed to see or copy; or
  - ✓ Is determined by us to be accurate and complete.

If we deny your requested amendment, we will inform in writing how to submit a statement of disagreement or a complaint, or to request that we include your amendment request in you health information that we maintain.
By submitting this form, I hereby request Mason City Clinic to amend or correct my health information, as described above, that Mason City Clinic maintains.
I understand that if Mason City Clinic agrees to my request, Mason City Clinic will provide the amendment/correction/to relevant third parties, including, but not limited to, the individuals that I identified above, and third parties with whom Mason City Clinic contracts to provide services to or on behalf of Mason City Clinic

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Name of Mason City Clinic staff who received this form Date form received

We have reviewed your request for Mason City Clinic to amend your health information and have determined that Mason City Clinic will grant your request.
Mason City Clinic has reviewed your request to amend your health information and has determined that it must deny your request. Reason for denial:

_____
_____