



# Amendment Request for Personal Information

Member name: \_\_\_\_\_ Member ID number: \_\_\_\_\_

Member address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Member telephone: \_\_\_\_\_ Member date of birth: \_\_\_\_\_

Fallon Health received a request for an amendment to your personal information on \_\_\_\_/\_\_\_\_/\_\_\_\_.

Type of record you want to amend (claim, case management notes, etc.): \_\_\_\_\_

\_\_\_\_\_

Information you would like to add/change in the record: \_\_\_\_\_

\_\_\_\_\_

Reason for add/change in the record: \_\_\_\_\_

Dates of record to amend: \_\_\_\_\_

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist or health care provider)?  Yes  No If yes, please specify the name(s) and address(es) of the organization(s) or individual: \_\_\_\_\_

\_\_\_\_\_

I understand Fallon may or may not supplement the medical record with an addendum based on my request, and, under no circumstance, is able to alter the original documentation of the medical record. This request for an addendum may be made part of my permanent record and will be sent to individuals/organizations identified as having relied on the content of my record.

Member (or personal representative) signature: \_\_\_\_\_

Relationship to member (if personal representative): \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail completed form to:**

Fallon Health  
10 Chestnut St.  
Worcester, MA 01608

**FOR FALLON USE ONLY** Amendment has been  Accepted  Denied

If denied, check reason for denial:

- PHI not created by Fallon
- PHI not part of the member's DRS
- Federal law does not require the PHI be made available for member inspection (psychotherapy notes, etc)
- PHI is accurate and complete
- Fallon cannot comply because we are not the originator, and the requestor cannot show that the originator is not available: \_\_\_\_\_

Privacy office must review all denials.

Reviewed

Privacy office signature: \_\_\_\_\_