Request to Amend Medical Record

I, *(name)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of *(address)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

request to amend my medical record held by Dr Clancy’s Practice (Practice) as described in Table A, below. I understand the Practice has the right to request me to attend a consultation with my doctor to discuss my medical record. I have been advised of the applicable fees for this service and that the fee will not be redeemable via Medicare. I understand that the Practice has the right to refuse my request if the Practice is satisfied that the information contained in my medical record is not incomplete, incorrect, irrelevant, out of date or misleading, or if the requested amendment contains information that is incorrect or misleading. The reasons for any refusal will be provided to me by the Practice in writing. If I am dissatisfied with the way my personal information has been handled, I may lodge a complaint addressed to the Practice Manager which will be dealt with according to the Practice’s compliant handling process.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian of patient

Table A - Description of requested amendment/s: