Group Health Cooperative
of South Central Wisconsin

Request for Medical Record Amendment

Purpose: The purpose of this form is to provide the GHC-SCW patient with the opportunity to exercise his/her right to request an amendment to his/her medical record.

_____ _____ _____
Patient Name (Please print) GHC# DOB

_____
Street Address City State Zip

_____ _____
E-Mail Address Phone Number

Brief description of the information I feel is incorrect or incomplete in my GHC-SCW medical record:

_____

_____

How I became aware of the incorrect or incomplete information:_____

The incorrect or incomplete information noted above should state:_____

_____

_____

Special Instructions or Additional Information:_____

_____

Signature

_____ _____
Signature of Patient or Personal Representative Date of Signature

Upon completion of form, return to the GHC-SCW Privacy Officer using one of these options:

USPS Mail	Fax	E-Mail via PDF
GHC-SCW Privacy Officer 1265 John Q. Hammons Drive Madison, WI 53717-1962	(608) 662-4917	privacy@ghcscw.com

Please direct questions to the GHC-SCW Privacy Officer at (608) 662-4899

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