Gov. Juan F. Luis Hospital & Medical Center
Christiansted, St. Croix, USVI

PATIENT REQUEST FOR AMENDMENT OF RECORDS

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. To request an amendment to your records, please complete and return this form.

PATIENT INFORMATION

Patient Name: ____ Date of Birth: _____________
Last First MI

Address: Telephone:

___________________________________ _________________________ (daytime)

___________________________________ _________________________ (evening)

____

AMENDMENT REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

1. Describe the information you would like amended?

____

____

____

2. What is your reason for making this request?

____

____

3. How is the entry incorrect, incomplete, or outdated?

____

____

____

4. What should the entry say to be more accurate or complete? (Please be specific)

____

____

____

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5. **Do you know of anyone who may have received or relied on the information in questions? ☐ Yes ☐ No**

   If yes, please provide the name and address of the organization(s) or individual(s).

____

____

____

6. **Is this request being made because of an emergency or other urgent situation? If so, please indicate the date you need the final decision and describe the nature of the emergency or urgency below. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate a reasonable request.**

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____

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am asking that Gov. Juan F. Luis Hospital & Medical Center amend my health information for the reasons I have explained above.

____

Signature of Patient or Personal Representative

____

Print Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative's Authority

SEND COMPELTED FORM TO:

Gov. Juan F. Luis Hospital & Medical Center

Health Information Management

4007 Estate Diamond Ruby

Christiansted, VI 00820

For Gov. Juan F. Luis Hospital & Medical Center Use Only:

Date Received: (MM/DD/YY) _____/_____/______

Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED

Patient Notified in Writing on This Date: (MM/DD/YY) _____/_____/______

Name of Medical Record Department Staff Member Processing this Request:

____