GO EAST MEDICAL SERVICES
行 健 醫 療 中 心

GEMS#:

NAME:

Date of Birth:

MEDICAL RECORD REQUEST FOR CORRECTION/AMENDMENT FORM

醫療記錄更正/修改申請

Date of Request
申請日期： _____/_____/_____

Name
姓名： _____

Phone Number
電話號碼： _____

Address
地址： _____

Email Address
電郵地址： _____

City
城市： _____

State
州： _____

Zip Code
郵政編碼： _____

Date(s) of Information to be Amended:
記錄修改日期：_____

Type: ☐ Progress Note 進度筆記
類型： ☐ Health Assessment 健康評估
☐ Other 其它: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Why? *(Add attachment if additional space is needed)*
請說明該記錄如何不準確或不完整，應如何更正以使其更加準確或完整，以及更正的理由。 *(如需額外空間，請添加附件)*

_____

_____

_____

_____

We may deny your request for an amendment if the information in our Medical Record was:
如果出現以下情況，我們可能會拒絕您修改醫療記錄的申請：

1) Accurate and complete;
該記錄準確並完整；

2) Not created by us, unless the person or entity that created the information is no longer available to make the amendment;
該記錄並非由行健醫療中心創建，除非創建該記錄的個人或機構無法再進行修改；

3) Not part of the medical information kept by or for GEMS;
該記錄不屬於行健醫療中心保存或為其保存的醫療記錄的一部分；

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4) Not part of the information which you would be permitted to inspect and copy (e.g. psychotherapy notes).
該記錄不屬於您被允許檢查和複製的資料的一部分（例如心理治療筆記）。

When amendment is accepted, your provider will supplement your Medical Record with an addendum since no one is allowed to alter the original documentation in a record.
當修改申請被批准後，您的醫師將通過附錄補充您的醫療記錄，因為任何人都不允許更改記錄中的原始文件。

We will respond to your request within 60 days. If this request is denied, you have the right to submit a written disagreement.
我們將在 60 天內回覆您的申請。 如果此申請被拒絕，您有權通過書面形式提交異議。

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past?
您是否希望將此修正發送給我們過往可能向其披露過該資料的任何人？

☐ Yes - If yes, please specify the name and address of the organization or individual. A copy of this form will now accompany each subsequent request for information regarding the dates covered in this entry.
是 - 如是，請註明機構或個人的名稱和地址。 此表格的副本將隨附於每個後續請求，以獲取有關本申請所涵蓋日期的資料。

☐ No
否

1. Name 姓名：_____ Address 地址：_____
2. Name 姓名：_____ Address 地址：_____
3. Name 姓名：_____ Address 地址：_____
4. Name 姓名：_____ Address 地址：_____
5. Name 姓名：_____ Address 地址：_____

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Signature of Patient or Legal Representative
病人或合法代表簽名

Date
日期

Name of Legal Representative
合法代表姓名

Relationship of Legal Representative
合法代表與病人的關係

Signature of Witness (Required if patient is unable to sign)
見證人簽名（病人無法自行簽字時此項必填）

Date
日期

Office Use Only:

Print Provider Name _____

Amendment/Correct ☐ Approve ☐ Deny

Denial Reason ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date _____

Date

Received by HIS Department _____

Routed to Provider _____

Received Response from Provider _____

Patient Notified _____

Comments from Healthcare Provider:

_____

_____

_____

Provider Signature: _____ Date: _____

Patient's Response to Provider's Statement: ☐ Agreement ☐ Disagreement