Endeavor Health℠

INSTRUCTIONS FOR REQUESTING AN AMENDMENT TO YOUR MEDICAL RECORD

You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete. The amendment would include the information you believe is in error, and your proposed corrections to that information.

To request an amendment to your medical information, please fill out this form in its entirety. You may mail, fax or deliver the form and any supporting documentation in person.

Please complete, sign and return the form to:

Endeavor Health
Attn. Health Information Management
4901 Searle Parkway, Suite 170
Skokie, IL 60077

***Or* submit via fax to 847-982-4499. Contact us at HIMservices@northshore.org or 847-982-4450 with questions.**

To deliver the form in person, please visit:

Evanston Hospital
Medical Records Department
2650 Ridge Avenue Room G225
Evanston, IL 60201
Hours: Monday through Friday
7:30 am to 4:00 pm

Glenbrook Hospital
Medical Records Department
2100 Pfingsten Road Room B206
Glenview, IL 60026
Hours: Monday through Friday
7:30 am to 4:00 pm

Swedish Covenant Hospital
Medical Records Department
2751 W Winona St, Room A152,
Chicago, IL 60625
Hours: Monday through Friday
7:30 am to 4:00 pm

Endeavor Health℠

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

0503-000
(4/2024)

Patient Information

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

MRN (If Known): _____ CONTACT PHONE: _____

CONTACT E-MAIL: _____

After review of my medical record, I do not find the following information to accurately reflect my condition/diagnosis/ treatment on the following service date(s):_____and should be supplemented with clarifying information in the form of an addendum to the medical record.

I understand the hospital/physician's office may or may not supplement the medical record with an addendum based on my request, and under no circumstances, is able to alter the original documentation of the medical record. In any event, this request for an addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information, unless I request otherwise.

PLEASE DESCRIBE YOUR REQUEST:

_____

_____

_____

_____

_____

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_____

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_____ _____

SIGNATURE (Patient or Legal Representative) **DATE**

Response

☐ In response to your request, your record has been amended.

☐ Your request has been made a part of your permanent medical record; however, your record has not been amended.

See attached letter for further explanation.

_____ _____

SIGNATURE **DATE**

Please complete, sign, and return this form to:

Endeavor Health – Attn. Health Information Management

4901 Searle Parkway, Suite 170

Skokie, IL 60077

With questions, please contact us at **HIMServices@northshore.org**