KAISER PERMANENTE®

Washington Region

Request to Correct or Amend Kaiser Permanente Health Information

Name _____

Member I.D. Number _____

Date of Birth (MM/DD/YYYY) _____

Options to submit this form: 1. In person, turn in to the business office at your local clinic. 2. Fax to Medical Records at 206-630-6849. 3. Scan and email a PDF to kpwa-roi@kp.org.

I have identified the following health care information in my health record to be incorrect or incomplete and request to have the information corrected or amended.

Date of record: _____ Provider (if known): _____

Please indicate what information is incorrect or incomplete and what the information should include to be more complete and accurate:

I understand that Kaiser Permanente will review my request for correction or amendment of records and respond within ten days of receipt, except in unusual circumstances. If unusual circumstances exist, Kaiser Permanente will notify me of any delay and respond within twenty-one days of receiving my request.

I understand that an amendment or correction is made in a manner that retains the original content but clearly indicates the amended content.

I understand that if Kaiser Permanente makes the requested change(s), a copy of the corrected/amended health information will be sent to me or to any persons known to have previously received the information and could rely upon it.

Date _____ Signature of patient or patient's authorized representative _____ Relationship to patient if not patient _____

Address (Street, City, State, Zip) _____

Email: _____ Phone: _____

Responses will be delivered by secure email whenever possible

Date request received by Kaiser Permanente: _____

This section is to be completed by a KAISER PERMANENTE PROVIDER or representative and returned to Release of Information (fax 206-630-6849 or kpwa-roi@kp.org) WITHIN THREE BUSINESS DAYS.

Date reviewed by: _____

Correction / Amendment has been: ☐ Accepted ☐ Denied ☐ Partially Accepted

Description of correction/amendment:

If denied, check reason for denial:

☐ The existing health information is accurate and complete.
☐ This health information was not created by this organization.
☐ This request was not part of the patient's health care records.
☐ The record no longer exists or cannot be found.

I have reviewed this request for correction/amendment and responded with the decision indicated above.

Provider Name (printed) _____ Provider Signature _____ Date _____