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Submit By Email

Privacy Forms

Saint Luke's Health System

Request for Amendment

Patient Name:_____ Birth Date:_____

Address:_____

City:_____ State: _____ Zip: _____Phone Number: (___)_____

Medical Record Number:_____(if known)

1. Information Requested to be changed:

Date of Visit/Service	Information Type (Office visit, ER note, Procedure Note, etc.)	Provider Name (if known)	Facility (if known)

2. Reason you are requesting the change (amendment):

☐ Inaccurate Information

☐ Diagnosis ☐ Medication ☐ Allergies ☐ Social History ☐ Medical/Surgical History ☐ Other (specify below)

☐ Missing Information

☐ Diagnosis ☐ Medication ☐ Allergies ☐ Social History ☐ Medical/Surgical History ☐ Other (specify below)

Explain how the information is inaccurate or what is missing (please attach a copy of record being disputed, if possible):

_____

_____

_____

_____

_____

3. What change to the documentation do you believe would improve the accuracy of your record?

_____

_____

_____

_____

_____

_____

Signature:_____Date:_____Time:_____

(Patient or Legal Representative)

Relationship to patient if someone other than patient:_____

Please Return Form to: SLHS Privacy Office via mail at
901 E. 104th St., Kansas City, MO 64131 or via email at privacy@saintlukeskc.org

While it is unlikely, there is a possibility that unsecure email could be intercepted and read by other parties besides the person to whom it is addressed. By sending your request by email, you are agreeing to accept these risks.

Privacy Staff send to HIM to File in Medical Record