DEMANN POU MODIFYE ENFÒMASYON MEDIKAL KI PWOTEJE YO
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Tanpri ranpli, siyen epi voye orijinal fòm nan bay responsab ki anchaj respè vi prive moun yo nan adrès sa a:
Cambridge Health Alliance
103 Garland St.
Everett, Ma 02149
Please complete, sign and mail the original form to the Privacy Officer at the following address:
Cambridge Health Alliance
103 Garland St.
Everett, Ma 02149

Seksyon 1: se pasyan an oswa reprezantan legal pasyan an ki dwe ranpli pati sa a
Section I: Completed by Patient or Patient's Personal Representative

Dat demann nan: _____
Date of Request:

Nimewo dosye medikal pasyan an: _____
Patient Medical Record Number:

Non pasyan an: _____
Patient's Name:

Adrès pasyan an: _____
Patient Address:

Dat nesans: _____
Date of Birth:

Nimewo telefòn: _____
Phone Number:

Mwen konprann doktè a gendwa aksepte owsa refize ajoute yon enfòmasyon nan dosye medikal la sou baz demann mwen an. Men li pa janm gen pèmisyon pou l modifye dokiman orijinal yo ki nan dosye medikal la. Yo ka entegre demann pou ajoute yon enfòmasyon sa a nan dosye medikal pèmanan mwen an epi yo ka voye l bay moun ak òganizasyon ki idantifye pi ba yo poutèt yo apiye ak fè konfyans sou sa k nan dosye medikal la.

I understand that the health care provider may or may not supplement the medical record with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical records. This request for an addendum may be made part of my permanent medical record and will be sent to individuals/organizations identified below as having relied on the content of my medical record.

Mwen mande pou yo modifye/korije enfòmasyon ki vin apre yo nan dosye medikal mwen an: (ki sa ki ta dwe ekri ki pi egzak oswa ki pi presi? Tanpri, endike dat pou chak sèvis ak dokiman ou ta renmen modifye yo).
I request that the following information be amended/corrected in my medical record: (What should the entry say to be more accurate or complete? Please specify the respective date(s) of service and document you would like amended.)

_____
_____
_____
_____
_____
_____

Rezon demann nan: (tanpri, esplike poukisa sa ki ekri a pa korèk oswa pa konplè.)
Reason for request: (Please explain why the entry is incorrect or incomplete.)

_____

_____

_____

Dat enfòmasyon yo dwe modifye yo: (pa egzanp, dat vizit la, dat tretman an oswa lòt dat sèvis swen sante yo)
Date(s) of information to be amended: (e.g., date of visit, treatment, or other health care services)

_____

_____

Èske ou ta renmen nou voye enfòmasyon ki modifye/korije sa a bay nenpòt moun ki te itilize l anvan oswa ki te fè l konfyans anvan (tankou doktè ou, famasyen ou, oswa lòt pwofesyonèl lasante)? □ Wi □ Non
Si ou reponn Wi, tanpri ekri non ak adrès moun yo pi ba a:
Would you like this amendment/correction sent to anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other health care provider? □ Yes □ No
If yes, please specify the name(s) and address(es):

_____

_____

_____

_____

Èske ou vle pou n mete nan dosye medikal ou a demann sa a ak modifikasyon an oswa lefètke yo refize modifikasyon an? □ Wi □ Non
Do you want this Request for Amendment, and the amendment or denial of amendment to be included in your medical record? □ Yes □ No

Pasyan an oswa reprezantan legal pasyan an: _____
Patient or Patient's Personal Representative:

Dat: _____   **Relasyon ak pasyan an:** _____
Date: *Relationship to Patient:*

Seksyon 2: se moun CHA ki otorize a ki dwe ranpli pati sa a
Section II: Completed by CHA Authorized Personnel

Demann pou modifye enfòmasyon medikal : □ Nou aksepte demann nan □ Nou refize demann nan
Dat:
Amendment has been: □ *Accepted* □ *Denied*
Date:

Dokiman nou mete ajou yo: □ Dosye elektronik/sou entènèt □ Dosye sou papye □ Toude kalite dosye
Updated Document(s): □ *Electronic/Online Record* □ *Paper Record* □ *Both*

Kòmantè oswa enstriksyon espesyal pwofesyonèl lasante a:
Healthcare Practitioner's Comments/Special Instructions:

_____
_____
_____
_____
_____
_____

Si n te refize demann nan, tcheke rezon an:
If denied, check the reason for denial:

□ Se pa Cambridge Health Alliance k te kreye enfòmasyon medikal ki pwoteje sa a
□ *Protected Health Information was not created by the Cambridge Health Alliance*

□ Enfòmasyon medikal ki pwoteje a pa fè pati tout dosye pasyan deziyen yo
□ *Protected Health Information is not part of the patient's Designated Record Set*

□ Pasyan an pa gen aksè ak enfòmasyon medikal ki pwoteje a poutèt règ Cambridge Health Alliance yo konsènan dwa pasyan genyen pou gen aksè ak pwòp enfòmasyon medikal ki pwoteje pa l la
□ *Protected Health Information is not accessible by the patient under the Cambridge Health Alliance's policy regarding the patient's right to access his or her Protected Health Information*

□ Enfòmasyon medikal ki pwoteje a egzak ak konplè
□ *Protected Health Information is accurate and complete*

□ Moun ki te mete enfòmasyon an nan dosye medikal la pa disponib poutèt _____
□ *Originator of the record is not available because*

Siyati responsab ki anchaj respè vi prive moun yo _____ **Dat:** _____
Signature of Privacy Officer   *Date:*

□ Nou te voye lèt bay moun nan kòmkwa nou refize demann nan
□ *Denial letter sent to individual*

Siyati staf la _____ **Dat:** _____
Signature of staff   *Date:*

Ekri non an ak tit la _____
Print Name & Title

Pou plis enfòmasyon, tanpri kontakte responsab ki anchaj respè vi prive moun yo nan nimewo: 617-591-4889
For more information, please contact the Privacy Officer at the following number: 617-591-4889

HAITIAN CREOLE