Record Amendment Request

Please complete the following information:

1. Today's date

2. Patient Full Legal Name _____

3. Birth date _____ 4.Patient # _____

5. Patient street address _____

City _____ State _____ Zip _____

6. Describe the information you want amended (e.g., lab test results, physician notes)

_____

7. Provide the date(s) of the information to be amended (e.g., date of office visit, treatment, or other health care services) _____

8. What is your reason for making this request? _____

_____

9. How is the entry incorrect or incomplete? _____

_____

10. Please attach the written amendment.

11. Do you know of anyone who may have received or relied on the information in question such as your doctor, pharmacist, health plan, or other health care provider? If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

_____

12. If the amendment is accepted, do we have your permission to share the amendment with individuals who have received this information? _____

Signature of patient/legal representative: _____

Date: _____

Individual other than patient: _____ Relationship: _____

Date