REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient name ____ Date of birth _______________

Patient number ______________________________________ Telephone _________________

Date of record to be amended __________________________

Type of record to be amended __________________________

NOTICE: Patients may seek to change information in their medical record in order to improve the accuracy or completeness of the information. However, by law the original information contained in the record cannot be erased or obliterated as a result of this amendment.

Please explain how the entry is incorrect or incomplete. What should the entry state in order to be more accurate or complete? Please attach additional pages as necessary.

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Signature of Patient or Authorized Party Date

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Printed Name

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Relationship to Patient