REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Date: _____
Patient name: _____
Birth date: _____ Phone: _____
Patient address: _____
Describe the information you would like to have amended:
_____
Date(s) of information to be amended (e.g., date of office visit(s):

What is your reason for making this request? (i.e., the information is incorrect, incomplete, or outdated)
_____
_____

How is the information you want to amend incorrect, incomplete, or outdated?
_____
_____

What should the entry say (or not say) to be more accurate or complete?
_____
_____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, health plan, or other health care provider)? Yes/No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

Signature of patient or legal representative:

_____

Date: _____