Request for Correction/Amendment of Health Information

Patient Name _____ **MR#** _____

Date of Birth _____ **Phone** _____

Date of entry to be amended _____

Type of entry to be amended _____

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

Would you like this amendment sent to anyone to whom we have already disclosed information to in the past? If so, please specify the name and address of the organization or individual.

_____ _____

Signature of Patient or Legal Representative **Date**

Comments of Healthcare Provider:

_____ _____

Signature of Provider **Date**