

## 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

