

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 (i.e., the information is incorrect, incomplete, or outdated)

How is the information you want to amend incorrect, incomplete, or outdated?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