

Request for Amendment

Patient Name: _____ ID#: P00_____

I request an amendment to my medical record. Date and substance of entry to be amended:

The reason I request this amendment is (why information is incomplete or inaccurate):

Please provide the names and addresses of other individuals or entities that have received the incorrect information and that you want to receive the amended information:

Signature _____ Date: _____

To be completed by Privacy Officer

Request granted or denied (circle one). If granted, date amendment made: _____

If denied, reason: _____

Date letter sent: _____

Signature of Privacy Officer _____ Date: _____