



Date of Request: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

Medical Record/Set: _____

Amendment Details

Original Date of Entry to Be Amended: _____ Type of Entry: _____

The amendment is requested for the following reason: _____

The amendment should be subsequently sent to the following organization:

Organization Name: _____ Contact: _____

Address: _____

I hereby acknowledge the above amendment be made.

Signature of Patient or Legal Patient Representative

Date

[Note: All requests will be provided to me within 30 days, unless an extension is required in which case I will be notified in writing. In any case, my request will not take longer than 60 days to fulfill.]

***** [Do Not Write in Section Below – For Healthcare Provider Use Only] *****

Amendment Has Been: Approved [] Denied [] Date of Decision: _____

If denied, reason is:

[] Record not created by organization [] Record not part of designated record set

[] Record is accurate and complete [] Record is not available for inspection by law

[] Other: _____

Extension Requested: [] Patient Notified: [] Date Notified: _____

Reason: _____

Signature of Healthcare Provider: _____ Date: _____