Request for Amendment Form

You may use this form to request an amendment to the information we maintain about you. After completing Section 1, you may deliver this document in person, fax it, or mail it to the facility where you received treatment. We will place a copy of your amendment in your record on receipt and route the original to the entry author. If the author adds a comment to this form, we will send you a copy. We will also send a copy to the individual(s) to whom you've instructed us to send it. We will then replace the copy we previously placed in your record with the original containing your request and the author's comments.

Section 1: To be completed by patient or legal representative

Name:
Date of Birth:
Social Security #:
Name of Document to be Amended:
Date of Entry to be Amended:
Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (Attach a separate document if necessary)_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name(s) and address(es) below. Attach a form indicating additional names and addresses if necessary.	
Name and Address #1:	Name and Address #2:
Signature of Individual Making Request:	
Relationship to Patient:	
Date of Signature:	

Section 2: To be completed by entry author, privacy officer, or other designated individual

Comments/Action Taken:
Author, Privacy Officer or Other Designate Signature:
Date of Signature: