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Medical Record Amendment/Correction

Patient name: _____ **Phone number:** _____

Patient address: _____
(Street or PO Box)

_____
(City) (State) (Zip)

1. Date of medical record entry to be corrected _____

2. Medical record language to be amended/corrected:

_____

_____

_____

3. Amendment/correction or material to be deleted:

_____

_____

_____

4. Reason for the amendment/correction: _____

5. Please help us identify people who may have received the original information

Name	Organization/Address	Phone Number

6. Do you authorize us to provide the information in items 3 and 4 to the people or organizations listed in item 5?

☐ Yes
☐ No

Do not provide the information to: _____

TO OUR PATIENTS: You have the right to submit a medical record amendment/correction to be made to your medical record. This right does not permit you to alter or change the original record created by your physician or members of the practice staff. We may deny your request to amend or correct your records.

☐ Amendment/correction Accepted ☐ Amendment/correction denied

Reason for Denial _____

This Amendment/Correction Sheet Is to be made a part of the medical record of:

_____ _____
(Patient name) (Date)