REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____ Name: _____

Address: _____ Date of Birth: _____

Please tell us what protected health information you want to amend (change).

_____

_____

_____

_____

Please tell us why you want this change(s).

_____

_____

_____

_____

If the information you requested is changed, we will notify the persons you designate of the change. Would you like us to do this?

☐ No Initials _____

☐ Yes Please list the persons' names and addresses.

_____

_____

_____

_____

We will notify you within 60 days about your request.

Signature of Patient or Designee: _____

If designee, give relationship: _____