

REQUEST FOR AMENDMENT OF A MEDICAL RECORD

This is to request the following information in my medical record, which I consider inaccurate, be corrected. I understand any amendments made to the medical record shall be added and the original preserved. I also understand any authorized release of information from my record will include this request for amendment.

Information considered inaccurate:

(Continue on Back)

Information considered accurate:

(Continue on Back)

Signature of Requestor

Date

Your request has been received: and made a part of your permanent medical record.
please see attached correspondence.

Director, HIMD

Date

Stamp Plate
