If you believe there is information in your medical record that may be inaccurate or incomplete, you have the right to request an amendment or clarification of information in your record

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify the exact amendment you would like to make to your medical record:

Please describe your reasoning for the above requested amendment:

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*If additional space is required, please attach a separate, typed or neatly written statement to this request form.

Patient/Guardian Signature: _____ Date: _____

Notary Public/Witness: _____

(If other than patient, cite authority and attach proof if applicable: _____)

Internal use only:

Request:

- ☐ Granted
- ☐ Denied
  - ☐ Information was created by a Third Party
  - ☐ Information is not part of the medical information kept by this practice
  - ☐ Information provided by the requesting part is inaccurate or incomplete
  - ☐ Information in the record is accurate

Completed by: _____ Date of Completed Amendment: _____