REQUEST FOR AMENDMENT TO RECORDS

Patient Full Name: ______________________________

DOB: ____________________ Patient MRN: ____________________

Specific Record information: ______________________________

Date of Visit: ______________________________

Reason for the Request: ______________________________

____

____

Specific Information to be changed: (It is acceptable to print out the specific note or information requesting to be changed and marking those changes and attaching to this request).

____

____

____

____

____

____

____

____

____

____

______________________________ ____________________
Signature Today's Date

FOR OFFICE USE ONLY:	Send Request To: Health Information Services Summit Orthopedics 710 Commerce Drive, Suite 200 Woodbury, MN 55125
	Change: ☐ Accepted ☐ Not Accepted - Explain ______________________________
	HIPAA Privacy Officer Signature: ____________________ Today's Date: __________
	Letter Sent to the Patient: ☐ Yes Date of Letter: ____________________

1571_4-21