

## **REQUEST FOR AMENDMENT TO RECORDS**

| Patient   | Full Name:   |               |
|-----------|--|---------------|
| DOB:      | Patient MRN:   |               |
| Specific  | Record information:  |               |
| Date of   | Visit:   |               |
| Reason    | for the Request:   |               |
|           | Information to be changed: (It is acceptable to print oution requesting to be changed and marking those change.  |               |
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|           |  |               |
|           |  |               |
|           |  |               |
| Signature |  | Today's Date  |
| SE 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:  |               |