PRIVATE HEALTHCARE FACILITIES

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Current Address _____ **Daytime Phone** _____
_____ **Evening Phone** _____

Patient Account Number (if available) _____

Type of information requested to be amended _____

Date of information requested to be amended _____

NOTICE: Patients may submit a request to change information in their medical record in order to improve the accuracy or completeness of the information. The original information contained in the record will not be removed as a result of this amendment.

Please explain how the entry in the record is incorrect or incomplete. What should the entry state in order for the record to be more accurate or complete? Please attach additional pages as necessary.

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_____

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_____ _____
Signature of Patient or Authorized Person Date

_____
Printed Name

_____
Relationship to Patient

Return this form to: Private Healthcare Facilities Privacy Officer
902 Kitty Hawk Rd, Ste 170487
Universal City TX 78148-3825
866-996-2340