montgomery medical associates, pc

Amendment of Health Record Request Form

PATIENT INFORMATION:

Patient Name:..... Date of Birth:.....

Mailing Address:.....

City & State:..... Zip Code:.....

Request Date:..... Account Number:.....

Please identify incorrect or incomplete information entered on your health record.

Which information needs to be amended?.....

Date of Entry to be amended:.....

Explain why the information is incorrect, or incomplete, and indicate what the information should say.
(You may attach any information you have to support your request.).....

If you would like this amendment/correction sent to anyone we may have disclosed this information to in the past, please list the name and mailing address of the organization or individual.

Name:.....

Address:.....

☐ I understand that the Department of Health and MMA may or may not amend my record based on my request.

☐ I understand that the Department of Health and MMA is not permitted to alter the original record.

☐ I understand this request for an amendment will be made part of my permanent record.

Signature of Patient or Personal Representative:..... Date:.....

For Medical Practice Use Only

Date received:..... ☐ Accepted ☐ Denied

Comments of Healthcare Provider: