Methodist Healthcare

HEALTH RECORD AMENDMENT REQUEST FORM

Patient's Name: _____ DOB: _____

Patient's Address: _____

Patient's Phone #: _____

Patient's Social Security #: _____ Date of Hospitalization: _____

Patient's Unit # and Billing #: _____

Date of Entry to be Amended: _____

Type of Entry to be Amended: _____

Please explain how the entry is inaccurate or incomplete.

_____

_____

_____

_____

_____

_____

What should the entry say to be more complete or accurate?

_____

_____

_____

_____

_____

_____

Please list the name and address of anyone to whom we may have disclosed the information to in the past.

Name	Address

Patient's Signature: _____ Date: _____

HIM Associate Signature: _____ Date Received: _____

* 1 3 0 *