Correct My Medical Record

I feel there is an error in my medical record, please correct it

Clinic Name _____ Date _____

Patient Name _____ Birthdate _____

Patient Address _____

City _____ State _____ ZipCode _____

Patient Email _____ Phone _____

What information do you want changed? Please include reasons to support your request (required): _____

_____

_____

_____

_____

_____

If the incorrect medical records were sent to somebody, you may request that the records be re-sent after the fix.

Recipient Of My Medical Records

Recipient Name _____

Address _____

City _____ State _____ ZipCode _____

Email _____ Phone _____

Recipient is: __ school __ employer/company __ other

__ I accept and request that the clinic release my medical records to some entity that may not be legally required to keep my information confidential.

Signature of Patient _____ Date _____
(or Parent/Guardian)

Internal Use Only

Received By _____ Date _____

Privacy Officer Reviewed _____ Date _____

Clinician Reviewed _____ Date _____

Comments _____

_____

_____

_____

