PULMONARY AND CRITICAL CARE ASSOCIATES OF BALTIMORE, PA

Request for Amendment of Health Information

Please fill in the following information:

Date: _____

Patient's name: _____

Birthdate: _____ SS#:_____

Patient: _____

Phone number (Home):_____ (Work):_____

I understand the health care provider may not supplement the medical records with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical record. This request for an addendum may be part of my permanent medical record and will be sent to individuals/ organizations identified below as having relied on the content of my medical record.

(PATIENT TO COMPLETE THIS SECTION)

Describe the information you want amended (e.g. lab test results, physician notes)

Date(s) of information to be amended (e.g. date of office visit, treatment, or other healthcare service)
_____What is your reason for making this request? _____
_____

What would you like to add/change to the record? _____
_____

Do you know of anyone who may have received or relied on this information in questions (such as your doctor, pharmacist, or other health care provider)? _____ Yes _____ No
If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).
_____

Date: _____

Signature of Patient:_____