Stormont-Vail HealthCare

Patient Amendment Request Form

Person(s) requesting amendment: ____

Stormont-Vail Regional Health Center ____ Cotton O'Neil Clinic ____
See Notice of Privacy Policy for list of clinics

Dates of the information to be amended (date of visit, date of procedure, and other services):
____

____

Description of information to be amended (e.g., medical record, lab results):
____

____

What is the reason for requesting amendments (e.g., outdated, incomplete or incorrect)?
____

____

How should the records be stated, i.e., what are the requested amendments?
____

____

Do you know of anyone who may have received or relied on the information in question (such as a doctor, health plan or other healthcare provider)? Yes______ No_______

If yes, who? ____
Address: ____

Signature of patient or legal representative: _______________________________ Date ________

Relationship of legal Representative to Patient
____ Date ______________________

Request for Amendment of Protected Health Information
Stormont-Vail Health*Care*
Risk Management Department
1500 S.W. 10th Ave.
Topeka, KS 66604
785-354-6343 Privacy Officer
Fax 785-354-6302

Patient Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________