

Patient Amendment Request Form

Person(s) requesting amendment: _____

Stormont Vail Hospital _____

Cotton O'Neil _____

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What is the reason for requesting amendments (e.g., outdated, incomplete or incorrect)?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