Patient Amendment Request Form

Person(s) requesting amendment:_____

Stormont Vail 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What is the reason for requesting amendments (e.g., outdated, incomplete or incorrect)?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 Integrity & Compliance 1500 S.W. 10th Ave. Topeka, KS 66604 785-354-6343 HIPAA Privacy Officer Fax 785-354-6398	Patient Name: Date of Birth: Today's Date: