Confluence HEALTH

HEALTH INFORMATION MANAGEMENT (HIM)
REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

DATE: _____

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Patient Phone: _____

Patient Mailing Address: _____

I request a change to my records.

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record:** _____

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Patient or legally authorized individual signature Date

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Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

We will review your request and respond within 10 days of receiving your request. A copy of your request will be added to your record.

You may contact the HIM Department at (509) 436-4026, if you have any additional questions requiring more information or want to report a problem about the handling of your information.

Please fill out and return this form to: P.O. Box 3510, Wenatchee, WA 98807