



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: _____

Multiple horizontal lines for providing details of the request.

Signature and Date fields, relationship to patient, and a review notice: 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