ALASKA NATIVE MEDICAL CENTER

REQUEST FOR AMENDMENT TO PROTECTED HEALTH INFORMATION

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Patient Name	Date of Birth	Patient Record Number
Patient Address	City, State, Zip	Telephone # Atlernate #

Date of Entry to Be Corrected/Amended	Type of Entry to be Amended

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

Name	Address
Name	Address
Name	Address

Signature of Patient or Legal/Personal Representative	Date

For Organization Use Only:

Date Received	Amendment has been □ Accepted □ Denied
Name and Title of Staff member processing request	Signature of Healthcare Practitioner (if denied)/Date