EMORY HEALTHCARE

EMORY HEALTHCARE

Request for Amendment of My Protected Health Information

Patient Name and Date of Birth

Date of entry to be amended

Patient Address

Type of record to be amended

Medical Record Number

Telephone Number

Name of Hospital or Clinic (i.e. Emory University Hospital, The Emory Clinic, etc.)

NOTICE: Patients may seek to change information in their medical record in order to improve the accuracy or completeness of the information. The original information contained in the record will not be erased or obliterated as a result of any amendment.

Please explain how the entry is incorrect or incomplete. What should the entry state in order to be more accurate or complete? Please attach additional pages as necessary.

Signature of Patient or Authorized Representative

Printed Name

Date

Relationship to Patient (if applicable)

This request was: Approved / Denied (circle one)

Reason for decision to approve/deny request:

Signature

Print Name

EMORY HEALTHCARE

EMORY HEALTHCARE

Authorization for Notification of Amendment to My Medical Record

Return to: The appropriate Health Information Management Department for which the amendment is being requested. Please reference facility addresses on our webpage at: https://www.emoryhealthcare.org/patients-visitors/medical-records.html

The following persons/entities should be notified of any changes made to my medical record at my request:

Name	Address

I hereby consent to the notification of the individuals and entities above regarding the requested changes made to my medical record.

Signature of Patient or Authorized Representative **Date**

Printed Name **Medical Record Number**