Behavioral Health and Health Facilities (BHHF)

REQUEST FOR CORRECTION OR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____

Patient Address: _____
Street Address

_____
City/State/Zip

Date of Birth: _____/_____/_____ SS# _____/_____/_____

AMENDMENT IS REQUESTED FOR THE FOLLOWING:

Date of Entry: _____

Type of Entry: _____

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

_____

_____

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? ☐ Yes ☐ No

If so, please specify the name and address of the organization or individual.

_____ _____
Name Address

_____ _____
Signature of Patient or Legal Representative Date

Healthcare Organization Use Only on reverse side of Request