REQUEST FOR AMENDMENT OF HEALTH INFORMATION

I request that HENDRICKS REGIONAL HEALTH amend certain information contained in my medical or billing record. I am providing a written detailed description of the requested amendment and the reasons for this request in the space below.

Patient Name:
Patient Address:
Date of Birth:
Detailed Description of Requested Amendment:
Reason for Requested Amendment:

I authorize Hendricks Regional Health to notify the following person/facility of the amendment:

Name _____
Address _____
City, State, Zip _____
Phone _____

Name _____
Address _____
City, State, Zip _____
Phone _____

_____ _____
Patient Signature Date

Office Use Only

Date Received: _____ Date Approved:_____

Date Record Amended:_____ Not Approved:_____

Date Patient Notified of decision:_____

Please mail completed form to: Director of Health Information Management
1000 E Main Street
P.O. Box 409
Danville, IN 46122

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