CONE HEALTH
The Network for Exceptional Care

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Forward this completed form to the Health Information Management Department at the Cone Health hospital, physician practice or other area where the record was created.

Patient Name _____ Date of Birth_____

Patient Medical Record Number _____ Telephone_____

Date of Record to Be Amended_____ Type of Record to Be Amended_____

NOTICE: Patients may seek to change information in their medical records 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 this 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 an additional (one) page as necessary.

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Please identify the names and addresses of the persons who must be notified of the amendments, such as your personal physician. We also will be notifying the following persons who have received health information from your medical records in order to conduct business with Cone Health.

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Signature of Patient or Authorized Party Date

_____ _____

Printed Name Relationship to Patient