



1500000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Return form to:
UVA Health System
Release of Information, Health Information Services
P.O. Box 800476
Charlottesville, VA 22908-0476

Patient's Name: _____ Date of Birth: _____
Patient's Address: _____
MRN: _____ Phone number: _____
Date(s) of Information to be 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?

Do you know of anyone who may have received the information in question? (Doctor or other health care provider?)

yes no

If yes, please specify the name(s) and address (es) of the organization(s) or individual(s)

I understand the health care provider may or may not supplement the medical record with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical record. If the request is accepted, I agree to have the Health System make reasonable efforts to provide the addendum to the individuals/ organizations identified above.

Patient or Legal Representative Signature Date

For Health System Use Only
Date Form Received: _____