PINEHURST NEUROLOGY

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient name _____ Date of birth _____

Medical Record number (completed by office)_____ Telephone _____

Date of record to be amended _____

Type of record to be amended _____

NOTICE: Patients may seek to change information in their medical record in order to improve the accuracy or completeness of the information. However, by law the original information contained in the record cannot 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 additional pages as necessary. Please write clearly and legibly.

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Signature of Patient or Authorized Party Date

_____ _____

Relationship to Patient Printed Name

Please return completed form to:
Attn: Medical Records Department
PO Box 1749
Pinehurst, NC 28370

Or Fax form to: 910-295-8780

****Do NOT email completed form as email address is NOT secure****