NEUROSURGICAL ASSOCIATES, LLC

HEALTH RECORD AMENDMENT FORM

Request for Correction/Amendment of Health Information

Patient Name: _____ DOB _____/_____/_____

Patient SSN: _____/_____/_____ Patient Phone Number: _____

Patient Address: _____

_____

Date of entry 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?

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

Name: _____ Phone Number: _____

Address: _____

_____

_____ Date: _____/_____/_____

Signature of Patient or Legal Representative