MITMedical
Medical Records Service
77 Massachusetts Ave., E23-023
Cambridge, MA 02139-4307
Phone: 617-253-4906
Fax: 617-258-0884

Request for Amendment of Protected Health Information

Patient name: _____
Last name First name Middle name

Date of birth: _____ MIT ID #: _____ Phone #: _____

Address: _____
Street City State ZIP

Date of request: _____

I request that the following information be amended in my medical record:

Please specify the date(s) of service, why and how the entry is incorrect or incomplete, and what the entry should say to make it more accurate or complete. If necessary, you may append one typewritten page to this document.

_____

_____

_____

_____ Text

_____

_____

Please specify any persons who may have received the protected information about you and who need the correction(s) or amendment(s), if accepted:

Name	Street	City, state, ZIP
Name	Street	City, state, ZIP
Name	Street	City, state, ZIP

_____ _____
Signature of patient or personal representative Date

_____ _____
Name of patient's personal representative (please print) Relationship to patient

Please mail or fax this form to the Medical Records Service address or fax number at the top of this page.