



**Medical Records Service**  
 77 Massachusetts Ave., E23-023  
 Cambridge, MA 02139-4307  
 Phone: 617-253-4906  
 Fax: 877-962-7236

## 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
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Name	Street	City, state, ZIP
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Name	Street	City, state, ZIP
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Signature of patient or personal representative	Date
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Name of patient's personal representative (please print)	Relationship to patient
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**Please mail or fax this form to the Medical Records Service address or fax number at the top of this page.**