WESTMED
MEDICAL GROUP

Amendment of Protected Health Information Request Form

I, _____ (Print Name), request that the protected health information in the medical record of _____ (Patient's Name) be amended as follows:

_____

_____

_____

_____ (Please describe the changes to the information)

The reason that I am requesting the information be amended is:

_____

_____

_____

_____
(Please provide a reason supporting your request, e.g., the information in the record is not accurate or is incomplete.)

I understand that WESTMED Medical Group is not required to amend information that is accurate and complete, that was not created by WESTMED Medical Group, that is not part of the medical information WESTMED Medical Group keeps, or is information I would not be permitted to inspect or copy.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority