Vanderbilt University Medical Center

Request for Amendment of Medical Information

Patient Amendment - Request

Patient Label or Patient Identifiers

PATIENT IDENTIFICATION	Name: _____ Date of Birth:_____ Address: _____ City: _____ State: ____ Zip Code: _____ Phone (with area code): _____
DATE OF ENTRY TO BE AMENDED	
PHYSICIAN/PROVIDER ON RECORD	

Please attach a copy of document(s) you want changed and explain the reason for the requested amendment. Your comments must be limited to 250 words or the front and back of this form. This form may become a part of your permanent medical record, so please use ball point pen and write legibly.

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relation: _____ **Date:** _____ **Time:** _____