

Request for Amendment of Health Information

Individual Name: _____

Individual Address: _____

Individual Date of Birth: _____

Individual SSN: _____

Specimen ID # (if known) _____

<i>Request #</i>	<i>Date of Request (mm/dd/yy)</i>	<i>Describe information you want Amended</i>	<i>Date(s) of Information to be Amended</i>	<i>Reason for Making this Request</i>	<i>What would you Like to Change or add to the Record?</i>
1					
2					
3					
4					

I am also requesting that you send notice of this amendment to the following individual or entities to whom you may have disclosed this particular information in the past.

Name: _____

Address: _____

I understand that the provider to whom I am making this request may or may not supplement my medical record with an addendum based upon this request, and under no circumstance, is able to alter the original documentation in my record. This request for an amendment may be made part of my permanent medical record and will be sent to the individuals/organizations identified by me.

Signature: _____ **Date:** _____

Please Mail Form to:

Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215