REQUEST FOR AMENDMENT OF MY MEDICAL RECORD

Patient Name: ____ Date of Birth: ____ /____ /_____

Street Address: ____ City: _______________ State: ______ Zip: _______

Phone Number: ____

After a review of my medical record, I do not believe that the original documentation made by Women's Health Associates of Southern Nevada, PLLC accurately and correctly reflects my treatment, condition or diagnosis on the following date ____ /____ /_____ and therefore, my medical record should be supplemented and corrected with clarifying information.

I understand that my physician or health care provider may or may not supplement or correct my record with an addendum to my medical record based upon this request. I understand that my physician or health care provider is not allowed to alter the original medical record. I understand that my request for an amendment will be made a permanent part of my medical record and will be sent with any future authorized request for my medical record.

I understand that, if WHASN denies my request for an amendment to my medical record, I have the opportunity to provide a statement of disagreement to contest the denial of my request.

The reason I request an amendment is as follows:

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____
Patient Name

____ ______/______/________
Patient/Health Care Agent/Guardian/Relative Signature Date

____
Description of Personal Representative's Authority