

WESTCHESTER MEDICAL CENTER
HEALTH INFORMATION MANAGEMENT DEPARTMENT

Manual
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SUBJECT: REQUEST TO AMEND MEDICAL RECORD

EFFECTIVE DATE: 1/2002	REVIEWED DATE: 2/8; 7/14	REVISED DATE: 7/14
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Medical Record Amendment Request Form

Date of request: _____ Medical Record No. _____

Patient Name: _____ Date of Birth _____

Patient Address:

Date of Entry to be Amended: _____

Type of Entry to be Amended: _____

Please change/amend my medical record because:
(*Explain what is to be changed/amended and why.*)

For my medical record to be more complete/accurate, it should say:

Name of person requesting change: _____ Signature: _____

Relationship to patient: _____