

Stamps Health Services

Request for an Amendment to Health Information

As a patient of a health care provider within Stamps Health Services, you may amend inaccurate or incomplete health information about you. If you want to amend your health information, you must complete this form and return it to: Manager, Customer Service, If you would like to amend information maintained by more than one provider, you must complete a separate form for each provider.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

GTID#: _____ Phone number: _____

Address: _____

Please specify the health care provider that holds the information to which you are requesting an amendment.

Provider Name: _____

Please describe the information that you want to amend (e.g.my address).

Please provide a reason to support your requested amendment.

Please explain how the information is inaccurate or incomplete.

Please state your amendment in the spaces provided below (you may attach additional information as necessary).

Signature of patient or personal representative Date

FOR INTERNAL USE ONLY

Received by: _____ Date: _____ Time: _____

Disposition: _____

Notification made:

By: _____ Title: _____ Date: _____ Time: _____

Method: _____