IDENTIFYING INFORMATION

Please provide the following details for the individual whose records you are requesting be amended. **Please print clearly**.

Patient Name: ____ Birth date: _______________

Address: ____

City: ______________________________ State: ___________ Zip: __________________

Home Telephone #: ___________________ Work Telephone #: ____________________

Identity of Requestor (if other than patient)—must be the parent of a minor, legal guardian, or holder of valid durable power of attorney for health care:

Requestor's name: ____

Relationship to patient: ____

(if legal guardian or holder of a power of attorney for healthcare, please attach legal documentation)

INFORMATION TO BE AMENDED

We can only amend records that were created by us. Requests to amend records created by other providers must be sent directly to them.

Describe the information in the records you want amended: _____________________________

____

Date(s) of service of the records to be amended: ______________________________________

Location of service: ____

Reason for the request: ____

How is the record incorrect, incomplete, or outdated? __________________________________

____

What should the record say to be more accurate or complete? ____________________________

____

SIGNATURES

Signature of Requestor: _________________________________ Date: _________________

Printed Name: ____

Mail request to: Evergreen Healthcare, 12040 NE 128th St, Mail Stop 49, Kirkland, WA 98034

Please note: This request for amendment of records will be processed within 10 days of receipt unless we notify you otherwise in writing. We will notify you in writing of our decision to agree or deny your request. If we deny your request, you do have the right to appeal or submit a letter of disagreement for inclusion in your record.

PATIENT REQUEST FOR AMENDMENT OF RECORDS

FORM ID ADM 553

Rev: 03/06

APPLY PATIENT LABEL HERE

Original – Medical Records