## PATIENT REQUEST: CORRECTION / AMENDMENT OF PROTECTED HEALTH INFORMATION

Purpose: To request amendment or correction of PHI maintained in patient health records\*

Please check the appropriate box and fill in the blar	nk as n	eeded:		
o			_ (name of facility)	
☐ All WellStar entities				
Please complete the following section (print clearly)	):			
Patient's Last Name First Name		MI	Birth Date (Month / I	Day / Year)
Street Address / Apt # (include complete mailing ac	ddress)	)	Medical Record Nun	nber (if known)
City State		Zip	Home Phone #	Alternate Phone #
REQUEST DETAILS: I hereby request amendment / compply):  Medical Records  Billing Records  Other: _ Type of information to be amended (please list specific	reports treatm	ent, or service):		
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Patient Request: Correction / Amendment of PHI
ITEM #1625

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