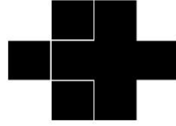

HOUSTON HEALTHCARE

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Information

Patient Name ____ Date of Birth ________________

Current Address____

Daytime Phone ____________________________ Evening Phone ______________________

Patient Account Number (if available) ____

Request for Amendment Information

Type of information requested for amendment ____

Date of information requested for amendment ____

Houston Healthcare facility related to request ____

- *Facilities: Houston Healthcare – Warner Robins, Houston Healthcare – Perry, Bonaire Med-Stop, Lake Joy Med-Stop, Pavilion Med-Stop, Pavilion Diagnostic Center, Pavilion Rehabilitation Center, The Surgery Center*

NOTICE: Patients may submit a request to change information in their medical record in order to improve the accuracy or completeness of the information. If approved, the original information contained in the medical record will not be removed from the record as a result of any amendment added to the record.

Please explain how the entry in the record is incorrect or incomplete. What should the entry state in order for the record to be more accurate or complete? Attach additional pages, as necessary.

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____ ________________

Signature of Patient or Authorized Person **Date**

____

Printed Name

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Relationship to Patient

Return this form to:

Houston Healthcare Privacy Officer
P.O. Box 2886
Warner Robins, GA 31099
(478) 322-5156

Copies of this form may also be returned in person to the Health Information Management (Medical Records) Department.

Form Revised 1/1/2023