



HOUSTON HEALTHCARE

### REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Current Address \_\_\_\_\_  
\_\_\_\_\_

Daytime Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_

Patient Account Number (if available) \_\_\_\_\_

Type of information requested to be amended \_\_\_\_\_

Date of information requested to be amended \_\_\_\_\_

List the Houston Healthcare Facility \_\_\_\_\_

Facilities: Houston Medical Center, Perry Hospital, Houston Lake Rehab, Houston Lake Med-Stop, Occupational Health & Wellness, Health Connections, EduCare, Pavilion Diagnostic Center, Pavilion Med-Stop, and Pavilion Rehab

**NOTICE: Patients may submit a request to change information in their medical record in order to improve the accuracy or completeness of the information. The original information contained in the record will not be removed as a result of this amendment.**

**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? Please attach additional pages as necessary.**

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_  
Signature of Patient or Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
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 can also be returned in person to the Health Information Management (Medical Records) Department.**