



1000005

Request for Personal Information Correction/Change

Please Note:

All requests made on this form will require at least two pieces of government-issued ID, one of which must have a photograph and it must reflect the correction you are requesting.

Acceptable Documents:

Driver's License, Birth Certificate (if the name you are requesting differs, you will also have to provide the documents that reflect the change. Example: Marriage License, Divorce Decree, Court Order), Social Security Card, Passport, State-Issued ID, Tribal ID, Matricula Consular, Others may be considered on an individual basis. For gender change, please provide appropriate physician letter, if you do not have a passport or Social Security card that has been changed.

I am requesting the following corrections/changes be made to my medical record:

Name as it appears **now** in the record: _____

Name being requested: _____

Social Security Number as it appears **now** in the record: _____ - _____ - _____

Correct Social Security Number: _____ - _____ - _____

Birth Date as it appears **now** in the record: _____ / _____ / _____
Month Day Year

Correct Birth Date: _____ / _____ / _____
Month Day Year

Gender as it appears **now** in the record: Male Female

Gender being requested: Male Female

Patient Name (Please Print) Patient Signature Date

Address (_____) Telephone

For Health Information Management Use Only

Documentation provided:

- | | | |
|--|---|---|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Driver's License | <input type="checkbox"/> Tribal ID |
| <input type="checkbox"/> Marriage License | <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Matricula Consular |
| <input type="checkbox"/> Divorce Decree | <input type="checkbox"/> Passport | <input type="checkbox"/> Physician Letter |
| <input type="checkbox"/> Court Order | <input type="checkbox"/> State-Issued ID | <input type="checkbox"/> _____ |

Make photocopy of proof presented and attach to request.

Record corrected in: (List Applications): _____

Request Completed By Date Scanned By Date

Patient Sent Notification Date