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How is the record incorrect, incomplete, or outdated?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: EvergreenHealth, 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.