SDMI

Request Correction/Amendment Protected Health Information

Name:	Birth Date:
Address:	City/State/Zip:
Medical Record Number:	Email:
Phone:	Date of Request:

Entry to be amended: _____

Date & Author of entry: _____

How is the entry incorrect or incomplete:_____

_____

What should the entry say to be more accurate or complete: _____

_____

_____

Any correction/amendment will be sent to the referring provider and uploaded to your Portal account. Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name/Address: _____

_____

_____

Note: If you have additional names, please attach an additional sheet to this page.

I understand that the SDMI may or may not amend the medical record with an amendment based on my request. SDMI will not alter the original medical record. In any event, this request for an amendment will be made part of my permanent record.

Signature of Patient:_____ Date:_____

Personal Representative(if applicable):_____

Reach us at : o 702.732.6000 w sdmi-lv.com a PO Box 36900 Las Vegas NV 89133