TRI-CITY CARDIOLOGY CONSULTANTS, PC

Request to amend the protected health information (PHI) maintained by TCC record.
Form #020

Patient Name: ____

Address: ____

Date of Birth: ___________________________

Phone (Day): ___________________________

Date of Service: ___________________________

Physician: ____

Staff documenting this request: ____

I request to amend the following information in my medical record:

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Patient or Personal Representative's Signature

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FOR OFFICE USE ONLY:

Request Reviewed by:____

Date:______________________________________

Request: ______ Approved _______Denied MD Signature:________________________

Reviewer Comments/Actions: ____

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Revised 12/30/15 as