SUMMIT ORTHOPEDICS

REQUEST FOR AMENDMENT TO RECORDS

Patient Full Name: _____

DOB: _____ Patient MRN: _____

Specific Record information: _____

Date of Visit: _____

Reason for the Request: _____

Specific Information to be changed: (It is acceptable to print out the specific note or information requesting to be changed and marking those changes and attaching to this request).

Signature Today's Date

FOR OFFICE USE ONLY:	Send Request To: Health Information Services Summit Orthopedics 710 Commerce Drive, Suite 200 Woodbury, MN 55125
	Change: ☐ Accepted ☐ Not Accepted - Explain _____
	HIPAA Privacy Officer Signature: _____ Today's Date: _____
	Letter Sent to the Patient: ☐ Yes Date of Letter: _____