

REQUEST TO AMEND (CHANGE) OR CORRECT PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name	First	MI	Date of Birth (Mo/D/Yr)	Medical Record #
Street Address		City	State	Zip Code

Select the DHS facility for which this request for amendment applies

<input type="checkbox"/> Los Angeles General Medical Center	<input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center			
<input type="checkbox"/> Olive View-UCLA Medical Center	<input type="checkbox"/> High Desert Regional Health Center			
<input type="checkbox"/> Harbor-UCLA Medical Center	<input type="checkbox"/> Martin Luther King, Jr. Outpatient Center			
<input type="checkbox"/> CHC/Health Center: _____				
<input type="checkbox"/> Other: _____				
Facility Name	Street Address	City	State	Zip Code

REQUEST DHS TO SEND THE RESPONSE TO THIS REQUEST TO:

Name	Phone Number (include area code)		
Street Address	FAX Number (include area code)		
City	State	Zip Code	E-mail Address

PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND (CHANGE) OR CORRECT:

---



---



---



---

PLEASE TELL US WHY YOU THINK THE AMENDMENT (CHANGE) OR CORRECTION THAT YOU ARE REQUESTING IS APPROPRIATE OR NECESSARY. YOU MUST PROVIDE A REASON:

---



---



---



---

MRUN

NAME

DOB/GENDER

