Name of Patient Birth Date Address Phone (home) City, State, Zip Code Phone (work) ☐ Valley Medical Center & Clinics I believe that the medical information made by (provider name): does not correctly show my condition/diagnosis/treatment on the following date(s): ______ and should be corrected. I understand: The original information in my medical record cannot be changed, but a comment, statement, or clarifying note can be added to the record. My care provider may not agree with my request to amend my record. If my request is denied, my amendment request and the denial will be filed in my medical record, but will only be released if I make that request. I request the following correction to my medical record (Please include reason why): If more space is needed, more pages can be attached. Signature (Patient or Legally Authorized Surrogate Decision Maker) Date Print Name You may send completed form to: **Valley Medical Center and Clinics** Mail: Release of Information 400 S 43rd Street P.O. Box 50010 Renton, WA 98058 Fax: 425.690.9407 Phone: 425.690.3406 Email: RecordsRequest@valleymed.org For Provider Use Only Provider Please Return To:___ Box___ ___ After Review ☐ In response to this request, a correction/addendum will be made part of your permanent medical record. ☐ This request has been made a part of your permanent medical record; however, your request for amendment has been denied for the following reason(s): **Provider Signature** NPI **Print Name** Date Time For Office Use Only: Sent to Patient: (Date) By (Name) Patient Label

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REQUEST AMENDMENT OF MED RECORD

Request for Correction or Amendment of the Medical Record