ALLEGHENY HEALTH NETWORK
REQUEST FOR AMENDMENT

Patient Name: _____ Birth Date:_____

Address:_____
Street City State Zip Code

Phone Number: _____ Medical Record Number: _____

Please list the relevant facility(ies), physician(s), and/or date(s) of entry associated with the records you are seeking to amend:

Facility: _____

Physician: _____

Date of disputed record entry: _____

Record type:

☐ Clinical (e.g., test results, medications, diagnoses, physician or nursing notes)

☐ Demographic or Financial

☐ Other (please describe): _____

In the space below, or on a separate attachment, please specifically explain the amendment you are seeking/along with the reason(s). Be sure to indicate whether you want language added or modified, and include your suggested language. If you choose, you may also provide us with the current record(s) in question to support our review:

_____

_____

_____

_____

_____ _____ _____
Signature of Patient or Legal Representative Date Time

If Representative, specify relationship and authority to act (include documentation such as POA):

_____

Please return this form to: Allegheny Health Network
Attn: Privacy Operations
120 Fifth Avenue Place, Suite 2114
Pittsburgh, PA 15222

The form may also be emailed to HighmarkHealthPrivacy@highmarkhealth.org. However, please note that there is an associated risk with sending information unsecured over the Internet.