



NH0775

NORTHSIDE HOSPITAL

English - Spanish

AFFIX PATIENT LABEL HERE

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

Apartment #

City, State, Zip

Date of Service: _____

Specific of Entry to be Amended: _____

Please explain how the entry is inaccurate or incomplete.

Please specify what the entry should say to be more accurate or complete.

Signature of Patient or Legal Guardian

Date / Time

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION