TRINITY PSYCH WELLNESS, LLC
Patient Amendment Request Form
(Please use one form for each individual request and complete entire form)

Patient Name: _____ Date: _____

Last 4 SSN: _____ Phone Number: (_____) _____- _____

Address: _____
_____
_____

1. Description of the information/statement you are requesting to be amended (e.g., health record, lab results): ***Attach a copy of record being disputed, if possible.**

   _____
   _____
   _____
   _____

2. Date of the information to be amended (***This may be the date of clinic visit, date of the note, procedure or other service**): _____

3. What is the reason for requesting this amendment (*Is the information inaccurate, incomplete, irrelevant, or untimely): _____
   _____

4. How should the records be stated, ***please specify in writing below**
   Example 1: Please change statement XYZ to the statement ABC
   Example 2: Please delete the entire statement from my health record

   _____
   _____
   _____
   _____
   _____

5. Do you know of anyone who may have received or relied on the information in question? ☐ Yes ☐ No If yes, who? _____
   _____

Signature of Patient or Personal Representative
* If you are the personal representative, please print your name, address & phone number and attach a copy of relevant legal documenqation (e.g., guardianship, POA, etc.)