**Patient Information:**

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Address: _____

Medical Record Number: _____ Account Number: _____

Date of Entry to be Amended: _____ Type of Entry to be Amended: _____

**Facility:**

☐ Cape Fear Valley Medical Center ☐ Behavioral Health Care ☐ Bladen Healthcare
☐ Cape Fear Valley Rehabilitation Center ☐ Highsmith-Rainey Specialty Hospital ☐ Hoke Hospital
☐ Other Facility: _____

What is the reason for the amendment?

_____

_____

_____

_____

What should the amended documentation be?

_____

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past?

☐ Yes ☐ No If yes, please specify the name and address of the organization or individual.

_____ _____
Name Address

_____ _____
Name Address

_____ _____
Signature of Patient or Legal Representative Date

This request for amendment of health information will be responded to within sixty days (60) of receipt of the request. An extension of thirty days (30) may be allowed, if needed, to process this request for amendment. If an extension is required, you will be notified in writing of the reason for the extension and the date by which the amendment will be processed. Thank you.