MITMedical

Massachusetts Institute of Technology
Medical Department
77 Massachusetts Avenue
E23-023
Cambridge, MA 02139

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

_____ /_____
Patient's Name (Former name)

Date of Birth _____ Social Security or MIT ID Number _____

Address: _____
Street City State Zip code

Patient Telephone Number: _____

Date and time of encounter: _____

Encounter type: _____

Please explain how the entry is incorrect or incomplete: _____

_____

What should the entry say to be more accurate or complete?_____

_____

Please specify any persons who may have received the protected information about you and who need the correction(s)/amendment(s), if accepted:

_____/_____/_____/____/_____
Name Street City State Zip code

_____/_____/_____/____/_____
Name Street City State Zip code

_____/_____/_____/____/_____
Name Street City State Zip code

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient's Personal Representative (please print) Relationship to Patient