



**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: Health Information/Medical Records
Attn: Data Integrity
1301 Carlisle Street
Natrona Heights, PA 15056

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