FERRIS STATE UNIVERSITY
College of Health Professions

REQUEST FOR AMENDMENT FORM

This form documents how the dental practice might document a patient's request to amend the patient's protected health information in the patient's designated record set.

To the Patient: Please use this form to ask our dental practice to change any information about you in our records. All requests for change to our records must be in writing and must state the reason for the change. You must return this form to the Privacy Officer listed on the bottom of this form.

Patient Information

Name of Patient (print name): _____

Patient's Date of Birth: _____ Today's Date: _____

Patient Signature: _____ Date: _____

For Personal Representative of the Patient:

Your Name: _____

Your Relationship to Patient: _____

Personal Representative Signature: _____ Date: _____

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____ Date: _____

Requested Amendment

Please describe in detail how you want your records changed:

_____
_____
_____
_____

Reason for requested change:

_____
_____

Contact Person

Please contact the dental practice's Privacy Officer if you have any questions relating to your request to amend records.

Privacy Officer: Dental Hygiene Clinic Operations Supervisor

Address: Ferris State University, College of Health Professions, 200 Ferris Drive, Big Rapids, MI 49307

Telephone: 231-591-2260