**ALLEGHENY HEALTH NETWORK**
**REQUEST FOR AMENDMENT**

**Exhibit B**

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, modified or deleted. If added or modified, 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):

_____