Specialty Behavioral Health

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Today's Date: _____ Patient's Name: _____

Patient Birth Date: _____ Patient Phone: _____

Patient Address: _____

Describe the information you would like to have amended:

_____

_____

Date(s) of information to be amended (e.g., date of office visit(s):

_____

_____

What is your reason for making this request? (i.e., the information is incorrect, incomplete, or outdated)

_____

How is the information you want to amend incorrect, incomplete, or outdated?

_____

What should the entry say (or not say) to be more accurate or complete?

_____

_____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, health plan, or other health care provider)? Yes/No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

Signature of patient or legal representative: _____ Date: _____

Mail this completed form to Specialty Behavioral Health, 3262 Holiday Ct., Ste. 208 La Jolla, CA 92037