NTMC
North Texas
Medical Center

REQUEST FOR AMENDMENT OF MEDICAL RECORD

Patient Name	Date of Birth
Patient Address	
Date(s) of Care to Be Reviewed for Amendment	
Please explain how you believe the medical record is incorrect or incomplete. What do you believe he medical record should say to be more accurate or complete? (Use additional sheets if needed and attach to this form.)	
Signature of Patient or Legal Guardian	Date
Signature of Employee Receiving Request	Date
Date Received	Date Reviewed
Comments of Healthcare Provider (Use additional sheets if needed and attach to this form.)	
Name of Healthcare Provider	Date
Signature of Healthcare Provider	Date