



NEW ENGLAND  
ORTHOPEDIC SURGEONS

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**HIPAA Patient Request for Amendment**

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Acct. # \_\_\_\_\_

Type and Date of Entry to be Amended:

- \_\_\_\_\_ Visit Note
- \_\_\_\_\_ Nurse Note
- \_\_\_\_\_ Hospital Note
- \_\_\_\_\_ Prescription Information
- \_\_\_\_\_ Patient History
- \_\_\_\_\_ Other (specify)

Please explain how the entry is inaccurate or incomplete:

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Please specify what the entry should say to be accurate or complete:

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Signature of Patient or Legal Guardian \_\_\_\_\_

Date: \_\_\_\_\_