CHIPPEWA COUNTY HEALTH DEPARTMENT

AMENDMENT to HEALTH INFORMATION

Patient's Right to Request an Amendment to Health Information

Please complete this form to request an amendment to your health information.

I, _____ request that Chippewa County Health Department amend:

__ my health information, or __ the health information of _____
(patient name)

for whom I am the personal representative.

I request the following amendment (attach additional pages if necessary):

_____

_____

_____

_____

The reason I request this amendment is:

_____

_____

Please provide this amendment to (persons or organizations and addresses):

_____

_____

Signature of requestor: _____

Date of request: _____

If the requestor is the patient's personal representative, relationship to patient:

_____