



HealthPartners Family of Care

405 Stageline Rd. •Hudson, WI 54016• (715) 531-6000

REQUEST TO AMEND MEDICAL RECORD

Attn: Medical Records Dept. 405 Stageline Road Hudson, WI 54016

Date: _____ Medical Record Number: _____

Patient's Name: _____

Patient's Date of Birth: _____ Social Security Number: _____

Reason for Amendment:

What you would like the amendment to say:

If you would like the amendment sent to someone please indicate name(s) and address:

Patient or Guarantor's Signature: _____

Review and recommendation by Medical Staff:

Reviewer's Signature _____ **Date:** _____

Disclosures:

Who received this form: _____ **Date:** _____

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Employee processing Disclosure: _____