Ketchum, Wood & Burgert, chtd. d/b/a

Pathology Associates
Request for Health Record Amendment

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

Pathology Associates has a detailed document called the "Notice of Privacy Practices". A copy of this document may be found at the Reception desk and on-line at www.kwbpathology.com. This document contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this request.

In accordance with the terms set forth in the Pathology Associates "Notice of Privacy Practices":

I understand that I may request that the patient's health care record be amended to correct incomplete or incorrect information.

I understand that Pathology Associates is not required to make such amendments.

I understand that I may file a statement of disagreement if the amendment request is denied and require that the request for amendment and any denial be attached in all future disclosures of the patient's protected health information.

I request the following information be amended to the patient's health record:

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_____ _____ _____

Patient or legally authorized individual signature Date Time

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Relationship to patient, if signed by anyone other than the patient
(parent, legal guardian, personal representative, etc.)