Vanderbilt University Medical Center Request for Amendment of Medical Information Patient Amendment - Request



PATIENT IDENTIFICATION	Name:	Date	of Birth:
	Address:		
	City:	State:	_ Zip Code:
	Phone (with area code):		
DATE OF ENTRY TO BE AMENDED			
PHYSICIAN/PROVIDER ON RECORD			
Please attach a copy of document(s) you want changed and explain the reason for the requested amendment. This form may become a part of your permanent medical record, so please use ball point pen and write legibly.			
Patient/Legal Representative Print Name: _			
Patient/Legal Representative Signature:			

Please return the completed form to: Vanderbilt University Medical Center Privacy Office 3841 Green Hills Village Drive, Suite 200 Nashville, TN 37215

Fax completed form to: (615) 343-6966 If you have any questions, call the VUMC Privacy Office at (615) 936-3594.