Vanderbilt University Medical Center

Request for Amendment of Medical Information

Patient Amendment - *Request*

Patient Label or Patient Identifiers

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: _____

Relation: _____ Date: _____ Time: _____

Please return the completed form to:
Vanderbilt University Medical Center Privacy Office
4560 Trousdale Drive, Suite 101
Nashville, Tn 37204
or
Fax completed form to: (615) 343-6966
If you have any questions, call the VUMC Privacy Office at (615) 936-3594.