ClassicSleepCare® LLC
Healthy Sleep. Beautiful Smiles.®

Patient Record Amendment Request Form

Date of Request: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

Medical Record/Set: _____

Amendment Details

Original Date of Entry to Be Amended: _____ Type of Entry: _____

The amendment is requested for the following reason: _____

_____

_____

The amendment should be subsequently sent to the following organization:

Organization Name:_____ Contact:_____

Address:_____

I hereby acknowledge the above amendment be made.

_____ _____

Signature of Patient or Legal Patient Representative *Date*

[Note: All requests will be provided to me within 30 days, unless an extension is required in which case I will be notified in writing. In any case, my request will not take longer than 60 days to fulfill.]

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[Do Not Write in Section Below – For Healthcare Provider Use Only]

Amendment Has Been: Approved [ ] Denied [ ] Date of Decision: _____

If denied, reason is:

[ ] Record not created by organization [ ] Record not part of designated record set

[ ] Record is accurate and complete [ ] Record is not available for inspection by law

[ ] Other: _____

Extension Requested: [ ] Patient Notified: [ ] Date Notified: _____

Reason: _____

Signature of Healthcare Provider: _____ Date:_____

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