MSU Health Care
Partnering with HENRY FORD HEALTH

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient name (Last, First, Middle): _____

Date of Birth: _____ Phone Number: _____

Address _____

What information do you request to be amended?

_____

_____

What is your reason for making this request?

_____

_____

☐ **I acknowledge that the health care provider may or may not supplement the medical record with an amendment based on my request, and under no circumstances is able to alter the original documentation of the medical record. This request for an amendment will be made part of my permanent medical record and will be sent to individuals/organizations identified above.**

_____ _____

Signature of Patient or Personal Representative **(Required)** Date **(Required)**

_____

Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient

RETURN TO
MSU Health Care Privacy Officer
804 Service Road
Suite A118
East Lansing, MI 48824

If you would a copy of your medical records, please complete the "Patient Authorization for Disclosure of Health Information" form available on the healthcare.msu.edu website or by calling the Medical Records office at (517) 353-4905.