TWIN CITIES ORTHOPEDICS

REQUEST FOR AMENDMENT TO RECORDS

Patient Name:	Date of birth:
Address:	Primary phone: Secondary phone:

Specify records to be amended:

Specify requested amendment:

Reason for amendment request:

Please identify any specific individuals who have received the unamended information and who you believe should receive the amended information if your request is accepted:

Signature of Patient or Patient's Representative: If signed by Patient's Representative, state authority to act on behalf of patient:

Upon completion of this form, please return it to the clinic you received services at.
Because this form requests changes to a legal document, identification is required.