MIT Health
Massachusetts Institute of Technology
77 Massachusetts Ave, Building E23
Cambridge, MA 02139

Request for Amendment of Protected Health Information

Patient Name _____ Date of Birth _____
First Name Middle Initial Last Name (month / day / year)

Preferred Name _____ Gender _____

Pronouns _____

Address _____ City _____ State _____ Zip _____

Date of Request _____

I request that the following information be amended in my medical record:

Please specify the date(s) of service, why and how the entry is incorrect or incomplete, and what the entry should say to make it more accurate or complete. If necessary, you may append one typewritten page to this document.

Please specify any persons who may have received the protected information about you and who need the correction(s) or amendment(s), if accepted:

Name	Street	City	State	ZIP
Name	Street	City	State	ZIP
Name	Street	City	State	ZIP

Signature of patient or personal representative _____ Date _____

Name of patient's personal representative (please print) _____ Relationship to patient _____

Please mail or fax this form to the Medical Records Service address or fax number at the top of this page