Request to Amend Records

Please complete the information below to request an amendment to your health records. The Facility will review your request and notify you as to whether your request has been approved or denied.

Patient Name	Date of Birth
Address	Telephone #

Please explain how your health records are incorrect or incomplete. What should they say to be more accurate or complete?

Please provide us with any persons or entities you would like us to disclose this amendment to. (Please use the back of this form is more space is needed)	

Patient/Personal Representative Signature	Date
Printed Name if Not the Patient	Relationship

When completed, please return to Hopkins Center Drug
Or Mail to:
Hopkins Center Drug
913 Hopkins Center
Hopkins, MN 55343

Internal Use Only	
Received and Reviewed by (Print)	Date
Amendment has been Accepted. ☐ Approved ☐ Denied (explain reason for denial)	
Patient/Personal Representative Notified of denial and reason? ☐ Yes ☐ No	