Mercy Medical Center Health Information Services 301 St. Paul Place Baltimore, MD 21202

REQUEST FOR AMENDMENT AND/OR CORRECTION OF THE MEDICAL RECORD

PATIENT NAME:					
	LAST	F	IRST	MIDDLE	
DATE OF BIRTH: SOCIA			AL SECURITY NUMBER:		
ADDRESS:					
CITY:	STATE:	ZIP:	PHONE:		
I have reviewed the medical record number for the admission of DATE(S) I recommend the following amendments and/or corrections a			<u></u> .		
these amendments are medical record. I also request for amendme	nd/or corrections wo o understand that N	ill upon approval b ⁄lercy Medical Cen	ecome a permar	nent part of the	
Signature of Patient (of Maryland, Article 43		sentative as provid	ded in the Annota	ated Code of the State	
Printed Name	 e	Signa	ture	 Date	
		•		*******	
Reviewed By:		Title:	_)ate:	