

Patient Amendment Request Form

Please fill out a form for each progress note which you are requesting a change.

Date: _____

Veteran Name: _____ Last four digits of SSN: _____

Address/City/State/Zip: _____

Description of the information to be amended (e.g., medical record, lab results):
*Attach a copy of record being disputed underlining the portion to be amended.

Date of the information to be amended (date of visit, procedure or other service):

What is the reason for requesting amendments (e.g. inaccurate, incomplete, irrelevant or untimely):

Please underline the verbiage you would like changed on the record, then indicate one of the two ways which you want your record changed:

1. Replace the identified portion of this record with the statement I have made below.
2. Remove identified portion of this record.

Do you know of anyone who may have received or relied on the information in question? Yes _____ No _____ If yes, who? _____

Veteran or Personal Representative Signature

* If personal representative, please print your name, address & phone number

Please send to:
Laurel S. Williamson
3600 30th Street, 00
Des Moines, IA 50310