Medical Information Change Acknowledgment

Date: [Insert Date]

To: [Patient's Name]

[Patient's Address]

[City, State, Zip Code]

Dear [Patient's Name],

We acknowledge receipt of your request to update your medical information. The following changes have been recorded in your medical records:

- Previous Condition: [Insert Previous Condition]
- New Condition: [Insert New Condition]
- Previous Medication: [Insert Previous Medication]
- New Medication: [Insert New Medication]
- Other Notes: [Insert Additional Information]

If you believe that any of the changes listed above are incorrect, please contact our office at [Insert Phone Number] or [Insert Email Address] as soon as possible.

Thank you for keeping your medical information up to date.

Sincerely,

[Your Name]

[Your Title]

[Your Institution/Practice Name]

[Contact Information]