

# Patient History Amendment Request

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Email Address]  
[Phone Number]  
[Date]

[Healthcare Provider's Name]  
[Healthcare Facility's Name]  
[Facility Address]  
[City, State, Zip Code]

Dear [Healthcare Provider's Name],

I am writing to formally request an amendment to my medical records. My name is [Your Full Name], and my date of birth is [Your Date of Birth]. My medical record number is [Your Medical Record Number].

On [Date of the Record], there is an entry that states [Description of the incorrect information]. This information is incorrect because [Explain why the information is incorrect and provide accurate information].

In accordance with HIPAA regulations, I am requesting that the above-mentioned information be corrected in my medical records. I have attached any relevant documents that support my request.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,  
[Your Signature (if sending a hard copy)]  
[Your Printed Name]