Name: _____

Date of Birth: _____

Employee ID: _____

Mailing Address: _____

_____

I request that Stanford University Occupational Health Center (SUOHC) make the following changes too my medical information:

_____

_____

_____

Please tell us why you want to make this change:

_____

_____

_____

If we decide to change the health information as you requested, we will make reasonable efforts to send the change to any person who received the information before it was changed. Tell us if there are any such persons who need the changed information:

Yes **No**

If yes, please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

We will also make a reasonable effort to send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

Yes **No**

We do not have to change your medical information if:

- SUOHC did not create the information
- The information in your record is accurate and complete
- You do not have the legal right to access the medical information that you want changed
- The medical information that you want changed is not part of the medical or billing records that we use to make decisions about you.

For more information about your privacy rights, see SUOHC's "Notice of Privacy Practices" available at the SUOHC office.

SIGNATURE

Signature: _____ Date: _____
(Employee/Personal Representative)

Name (Print): _____
(Employee/Personal Representative)

If signed by other than the employee, indicate relationship or authority to sign:

_____

CONTACT INFORMATION

Please tell us where we can contact you:

Address: _____

Phone Number: _____