APPALACHIAN STATE UNIVERSITY
COMMUNICATION DISORDERS CLINIC

REQUEST TO AMEND HEALTH INFORMATION

Name:
Address:
Date of Birth:
Phone:

Describe how the information found in your medical record(s) is incomplete or incorrect. What changes should be made to the information?

Does the information need to be sent to anyone to whom the Communication Disorders Clinic may have disclosed the information? If so, please indicate the name and address of the individual or organization that should be notified if the amendment is accepted.

To our clients: You have the right to submit a Request to Amend Health Information and have it added to your file. If the Clinic denies a part of your request for a change, we will give you a written explanation of the denial.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____

Client, Parent, or Legal Guardian Date