



YUMA REGIONAL MEDICAL CENTER

Caring for the growing needs of our communities

Request for Change in the Medical Record

I, _____, have reviewed my health record and request the following change(s) be made. (Please be specific as to what you would like to have changed. Please refer to the attached guidelines and instructions for completing the Request to Change the Health Record.

If additional space is needed, please continue on reverse.

Please check one of the boxes below:

I would like my Change Request emailed to me (email address): _____

I would like my Change Request mailed to my on file mailing address

Patient Signature

Date

Physician Section

I **APPROVE** the patient requested change(s) in the Health Record, and will be correcting the change by dictating or adding an addendum to the document in question accordingly.

Physician Signature

Date

OR

I have **NOT** approved the patient requested change(s) in the Health Record.

Physician Signature

Date