

3. What is your reason for making this request?

4. How is the entry incorrect?

5. What should the entry say to be more accurate? (Please be as specific as possible)

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?

yes no

If yes, please specify the name(s) and address(es) of the organization(s) or individuals(s).

Printed name of Patient (or Personal Representative): _____

Relationship to Patient: _____

Please print and sign with blue or black ink.

Signature of Patient (or Personal Representative) _____ Date _____

Please submit the completed form via email, fax or mail:

Fax # 856-810-3747

Address to email: HIMROI@Weismanchildrens.com

Address to mail:

Health Information Management, 92 Brick Road, Marlton New Jersey 08053