Onslow Memorial Hospital
P.O. Box 1358, 317 Western Boulevard
Jacksonville, NC 28541-1358
Telephone: (910) 577-2509
Fax: (910) 577-2609

REQUEST FOR AMENDMENT

Our patients have the right to request that we amend information contained in our records that may be used to make decisions about their care. Please see our Notice of Privacy Practices for a more detailed description of these rights. At Onslow Memorial Hospital we pledge to treat all requests for amendment of information in a manner that is respectful and helpful. To request an amendment to your records, please complete the following form and return it to the Medical Records Department located at Onslow Memorial Hospital.

Please complete the following form in its entirety.

Patient Name	First	MI	Last
Patient Information	Medical Record Number	Social Security Number	Date of Birth (MM/DD/YYYY)
Patient's Mailing Address	Street Address		Apt.
	City	State	Zip
Patient's Contact Information	Day Phone	Evening Phone	
What would you like to amend? Please use the space below to indicate what information you would like to amend (attach a separate page, if necessary).			

…w do you believe the information should be amended? Please use the space below to indicate how you believe the information should be amended (attach a separate page, if necessary).	
Why do you believe the information should be amended? Please use the space below to indicate why you believe the information should be amended (attach a separate page, if necessary). Your request may be denied if you do not provide a reason to support your request.	
Notification	**If your request for amendment is approved, we will make a reasonable effort to forward the amendment to individuals or organizations that you believe should be notified.** In the space below, please indicate the names and addresses of individuals or organizations that you believe should be notified (attach a separate page, if necessary).

Patient Understanding and Signature

By signing below, I am requesting that OMH amend my health information as I have explained above.

Signature of Patient or Personal Representative	**Printed Name of Patient or Personal Representative**
Date	**Description of Personal Representative's Authority**