



**The
Orthopaedic
and Sports
Medicine Center L.L.C.**

Leaders in Specialty Orthopaedic Care

REQUEST TO AMEND MEDICAL RECORD

Note to patients: Please use this form to make a request that our practice amend or make correction to information maintained about you.

Please return to:

Orthopedic and Sports Medicine Center,
ATTN: LINDA BOUNDS, Privacy Official
2000 Medical Parkway, Suite 101, Annapolis MD 21401.

PATIENT INFORMATION

Name of Patient: _____

Signature of Patient: _____

Date: _____

Patient's Date of Birth: _____

FOR PERSONAL REPRESENTATIVES OF PATIENT

Your Name: _____

Relationship to Patient: _____

REQUESTED AMENDMENT: Please describe in detail how you want your records amended.

REASON FOR REQUESTED AMENDMENT

CONTACT PERSON: Please contact our practice's privacy official, Linda Bounds at 410 268-8862, if you have any questions relating to your request to amend records.

SIGNATURES

Patient: _____ Date: _____

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of personal representative: _____ Date: _____

Print name: _____