Complete and send.

Reset Form

MAYO CLINIC

Request for Amendment of Health Information

Form content retained in medical record.
Route to HIMS Amendment Team (himsamendmentreq@mayo.edu).

TO BE SCANNED

(complete fields or place patient label here)

Patient Name (First Middle Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

Instructions: To be completed by patient (or patient representative*) to request an amendment to their medical record.

Patient Information

Address (Street, City, State, Country, ZIP or Postal Code)	
Phone	Email
Service Date(s) if Known (mm-dd-yyyy)	

What protected health information do you want changed? Include a detailed explanation and/or attach a copy of the record with the changes requested as outlined on the Medical Record Information for an Amendment Request (MC5256-03).

Reason(s) to Support Your Request (required)

If approved, would you like this amendment to be sent to anyone to whom we have disclosed the information to in the past?
☐ Yes ☐ No
If "Yes," specify the name and address of the organization or individual.

Mayo Clinic will also identify and notify any other parties it knows have received the health information that requires amendment and will document these notifications.

Signature

Patient or Representative Signature ▶ Signature Required	Date (mm-dd-yyyy)
Representative Printed Name (First Middle Last)	Relationship to Patient

*Parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy.

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