Cheyenne Regional

Patient Chart Correction/ Amendment

STAMPER OR PATIENT LABEL

Patient Information:

Name of Patient _____
(Last, First, Middle Initial)

Street Address: _____ City: _____ State: ___ Zip: _____

DOB: ____/_____/_____ Phone Number: _____

Content to be changed (Please attach a copy of the documentation that you would like corrected or amended):

_____

_____

_____

_____

_____

Reason for the change:

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Please note each case will be reviewed individually and written notification will be provided within 60 days of receiving your request according to HIPAA Privacy Regulations (45 C.F.R §164.526)

Please Mail or Fax Forms to:
Cheyenne Regional
Health Information Management Department
214 E 23rd St
Cheyenne, Wy 82001
Fax: (307) 432-3108

Hospital Use Only
Date Rec'd: _____
Initials: _____