PRINT SAVE AS EMAIL RESET

BOSTON MEDICAL CENTER

1000005

Request for Personal Information Correction/Change

Please Note:

All requests made on this form will require at least two pieces of government-issued ID, one of which must have a photograph, and it MUST reflect the correction you are requesting.

Acceptable Documents:

Driver's License, Birth Certificate (if the name you are requesting differs, you will also have to provide the documents that reflect the change. Example: Marriage License, Divorce Decree, Court Order), Social Security Card, Passport, State-issued ID, Tribal ID, Matricula Consular. Others may be considered on an individual basis. For legal sex change, please provide an appropriate physician letter if you do not have a passport or Identification Card that has been changed.

Please complete the form in its entirety. This will allow our team to confirm that we have the correct patient record.

I am requesting the following corrections/changes be made to my medical record:

Name as it appears **now** in the record: _____

Name being requested: _____

Social Security Number as it appears **now** in the record: _____ - _____ - _____

Correct Social Security Number: _____ - _____ - _____

Birth Date as it appears **now** in the record: _____ _____ _____
Month Day Year

Correct Birth Date: _____ _____ _____
Month Day Year

Legal Sex as it appears **now** in the record: _____

Legal Sex being requested: _____

_____ _____ _____
Patient Name (Please Print) Patient Signature Date

_____ (_____) _____ - _____
Address Telephone

For Office Use Only

Documentation provided:

- ☐ Birth Certificate
- ☐ Marriage License
- ☐ Divorce Decree
- ☐ Court Order
- ☐ Driver's License
- ☐ Social Security Card
- ☐ Passport
- ☐ State-Issued ID
- ☐ Tribal ID
- ☐ Matricula Consular
- ☐ Physician Letter
- ☐ _____

Please scan the documentation to the document table when received. If received by HIM, make a photocopy of the proof presented and attach it to the request.

_____ _____ _____ _____
Request Completed By Date Scanned By Date

_____ _____
Patient Sent Notification Date