

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Employee ID: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

**I request that Stanford University Occupational Health Center (SUOHC) make the following changes to my medical information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please tell us why you want to make this change:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If we decide to change the health information as you requested, we will make reasonable efforts to send the change to any person who received the information before it was changed. Tell us if there are any such persons who need the changed information:**

Yes     No

**If yes, please list the persons' names and addresses:**

_____	_____
_____	_____
_____	_____

**We will also make a reasonable effort to send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?**

Yes     No

We do not have to change your medical information if:

- SUOHC did not create the information
- The information in your record is accurate and complete
- You do not have the legal right to access the medical information that you want changed
- The medical information that you want changed is not part of the medical or billing records that we use to make decisions about you.

For more information about your privacy rights, see SUOHC's "Notice of Privacy Practices" available at the SUOHC office.

**SIGNATURE**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Employee/Personal Representative)

Name (Print): \_\_\_\_\_  
(Employee/Personal Representative)

If signed by other than the employee, indicate relationship or authority to sign:

\_\_\_\_\_

**CONTACT INFORMATION**

Please tell us where we can contact you:

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_