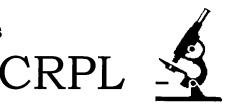
CENTRAL REGIONAL PATHOLOGY LABORATORIES 2945 Hazelwood Street, Suite #310 Maplewood, MN 55109 (651) 264-1500 fax (651) 264-1646



Request for Amendment/Correction of Health Information

Patient Name:	Date of Birth:
Patient Address:	
Clinic Account #/Physician:	
	· · · · · · · · · · · · · · · · · · ·
Specify record to be amended (report number):	
Collection date:	
Specify requested amendment/correction:	
Reason for amendment/correction request:	
Please identify any individuals who may have received t whom you believe should receive the amended informa	tion if your request is accepted:
Name of person requesting amendment:	
Signature of person requesting amendment:	Date: