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 the non-amended information and whom
you believe should receive the amended information if your request is accepted:

Name of person requesting amendment:

Signature of person requesting amendment: _____ Date: _____