Request for Amendments/Corrections to Medical Record

To change demographic information you do not need to use this form. Please contact Customer Service at 800-469-7423

Patient Information:			
Patient Name			Patient ID #
Current Address	City	State	Zip
Last four digits of Social Security Number XXX-XX	Phone Number ( )	Date of Birth / /	

I request that the following information be amended/corrected in my medical record (please explain what the entry should say to be more accurate and complete):

_____

_____

_____

Reason for request (please explain why the entry is incorrect or incomplete):

_____

_____

If your request is accepted and the amendment is made, a copy of the amended information will be sent to anyone who has previously received this information. If there is anyone else you would like to receive this amendment, please specify the name(s) and address(es) of those individuals:

_____

_____

I understand that:

- Myriad will respond to my request within 60 days or notify me that an extension of an extra 30 days (or less) is required to respond.
- My request will be considered by Myriad, but may be denied if the information was not created by Myriad, or is not part of my medical or billing record, would not be available to me under applicable law, or is determined to be accurate and complete.

Patient or Personal Representative Signature	Date
Print Personal Representative Name *(please attach applicable legal documentation)*	Relationship to Patient

Please send this form to: Myriad, Attn: Privacy Office, 320 Wakara Way, Salt Lake City, UT 84108

Date request received:	Reason for denial: ☐ The information was not created by Myriad
☐ Amendment accepted ☐ Amendment denied	☐ The information is not available to the patient under applicable law ☐ The information is not part of the medical record ☐ The information has been determined to be accurate and complete
Date notification sent to patient or personal representative:	☐ Amendment/Correction completed ☐ Amendment sent to individuals/entities designated above, and those who previously received this information
Representative name/signature	Date