

REQUEST TO ADD A STATEMENT TO A MEDICAL RECORD	
Patient Name:	Date of Birth:
Address:	
Phone:	Medical Record #
to my medical record. I understand disclosures of the original documenta	n addendum (up to 250 words per incorrect item) be added that this addendum will be included with any future ation permitted by law or authorized by me. in the space provided below, or attach your request on a
(Signature of Patient or representative)	Date

(Please Print Name)	Relationship to patient (if other than patient )
When you have completed this form, please return it to the designated FCC Clinic Front Office We will respond to your request within 30 days of receipt	
Date received at FCC Front Office:	_