Request to Receive and/or Correct Medical Records

Date: _____ Mailed certified, return receipt - Number: _____

To (Agency Name) _____

Address/City/State/Zip _____

Health Insurance Number_____

From: _____

Address/City/State/Zip: _____

Phone Number_____ cell number _____

Email _____

I may be a victim of medical identity theft because _____

_____

_____

The medical records your agency maintains about me may include information about someone else. This information, if not corrected, may adversely affect my personal health care and/or deny me insurance benefits.

I am requesting the following:

- A copy of my medical records so that I can review them for information that may not pertain to me.
- In the event that you cannot send the records to me, I would like to set a date to come in and review the records in your local office.
- •Once I review the records, to have a "statement of disagreement" placed in a conspicuous location on my medical records. It will serve as an alert for other health providers of the medical identity theft issue and to verify my medical information prior to making a diagnosis or prescribing medication.
- That you notify any other entity that you have shared my records with of the corrections.
- A letter from your agency confirming that the corrections have been made.

Your agency may have received fraudulent information from an identity thief. It is apparent that we both have a vested interest in identifying misinformation and resolving this situation. Should you have any questions regarding my request, please contact me at the phone number/s above.

_____ _____

Signature Date

Addendum:
List items of inaccurate information, including dates when possible.