FORM E

AMENDMENT ACCEPTANCE – NOTIFICATION FORM

I request and authorize the Alabama Department of Public Health to notify the health care providers or entities listed below of the amendment(s) to the medical record of:

Patient Name: ____

Date of Birth: ____________________ SSN: XXX-XX- _______

List of Providers/Entities that need to be notified of Amendment:

____________________	____________________
Name	Name
____________________	____________________
____________________	____________________
Address	Address
____________________	____________________
Phone Number	Phone Number
____________________	____________________
Name	Name
____________________	____________________
____________________	____________________
Address	Address
____________________	____________________
Phone Number	Phone Number

______________________________ ______________

[Signature/Title, if legal representative*] Date

*May be requested to submit evidence of representative status.