FORM D

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 records of _____.

[Name of patient]

Signed: _____ _____

Name – (Title, if legal representative) *Date*

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**
_____	_____
Name	**Name**
_____	_____
_____	_____
Address	**Address**
_____	_____
Phone Number	**Phone Number**