VA Central Iowa Health Care System
Medical Record Amendment Request Form
(Please use one form for each request and complete the form in its entirety)

Patient Name: _____ Last 4 SSN: _____

Address: _____

_____

_____

1. Description of the information/statement you are requesting to be amended (e.g., health record, lab results): ***Attach a copy of record being disputed, if possible.**
   _____
   _____
   _____
   _____

2. Date of the information to be amended (***This may be the date of clinic visit, date of the note, procedure or other service**): _____

3. What is the reason for requesting this amendment (*Is the information inaccurate, incomplete, irrelevant, or untimely):

   ☐ Inaccurate ☐ Incomplete ☐ Irrelevant ☐ Untimely

4. How should the records be stated, ***please specify in writing below**
   Example 1: Please change statement XYZ to the statement ABC
   Example 2: Please delete the entire statement from my health record
   _____
   _____
   _____
   _____

5. Do you know of anyone who may have received or relied on the information in question?
   ☐ Yes ☐ No If yes, who? _____
   _____

***Veteran or Personal Representative Signature** (wet signature only)*

* If you are the personal representative, please print your name, address & phone number and attach a copy of relevant legal documentation (e.g., guardianship, POA, etc.)

Mail To:
VA Central Iowa HCS
Attn: Privacy Officer, OAS-D
3600 30th Street
Des Moines, IA 50310

Questions? Call 515-699-5999 Ext. 2-4465