



Individual Name:
Individual Address:
Date of Birth:
SSN:
Specimen Identification No:

Please consider this a request for the exercise of my rights under federal and state laws to request confidential communications of my Personal Information. I understand that my request will be reviewed and that in some circumstances I may not have the right to access all information. I understand that my request will be acted upon as quickly as possible but no later than the timeframes allowed by the laws of my state. I further understand that I will be contacted when my records are available for inspection.

Table with 2 columns: Question/Field and Answer. Rows include: Date of Information you seek to be amended, Describe the information you want amended, Explain how the entry is incorrect or incomplete, What should the entry say to be more accurate or complete?, Reason for requested amendment.

I am also requesting you send notice of this amendment to the following individual or entities to whom you may have disclosed this particular information in the past.
[Blank lines for names]

I understand that the provider to whom I am making this request may or may not supplement my record with an addendum based upon this request, and under no circumstance, is able to alter the original documentation in my record. This request for an amendment may be made part of my permanent record and will be sent to the individuals/organizations identified by me above.

Signature: _____ Date: _____

Please Mail Form to:
Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215