



If your request to amend is granted, we will make reasonable efforts to inform certain individuals/organizations of the amendment.

We will provide a copy of the amendment to those individuals/organizations identified by you as having previously received the protected health information that is the subject of this request and are in need of the amendment.

By providing us with the names and addresses of the individuals/organizations, you are hereby agreeing to allow us to notify them of the amendment and provide them with a copy.

**Name and Address**

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**Name and Address**

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**Name and Address**

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**Name and Address**

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**Patient's Signature**

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**Date**