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Easton, PA 18040
(610) 559-8001
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Date: _____

Insurance Name: _____

Address: _____

RE: Request to amend patient records

Patient Name: _____

Dear Sir or Madam:

It has come to my attention that your records regarding my health status are in error.

At this time I require you to amend the records to reflect the following:

I expect these changes to be made within 5 business days and the amended copies sent to my dental provider. Thank you in advance for your anticipated cooperation in getting these records changed within the next 5 days.

Sincerely,

Patient's Name

Patient's Signature