MITMedical

Patient Information Change/Correction Form

Medical Records, E23-023
77 Massachusetts Avenue
Cambridge, MA 02139-4307

Today's date _____ MIT ID # _____ **Status:** ☐ Employee ☐ Student
☐ Other _____

Please check one of the following boxes for information to be changed.

Patient name (former) _____ _____ ___ _____
Last name First name M.I. D.O.B.

☐ **Name Change**
Patient new name _____ _____ ___
Last name First name M.I.

☐ **Gender**
Please change gender from: ☐ F to M ☐ M to F

☐ **Medical Record Number Change**
Please change Medical Record Number – current # _____

☐ **Change D.O.B.**
Please change date of birth from _____ to _____

E-mail _____ Telephone # _____

_____ _____
Name of personal representative **(please print)** Signature of patient or personal representative

Personal representative's relationship to patient _____

For name, D.O.B. and gender changes, please attach the following: **current state identification, Massachusetts driver's license, birth certificate, and/or court papers.**

For office use only:

I.D. provided _____
Date received _____
Received by _____
New MRN _____
Processed by _____