NOTICE OF CORRECTED INFORMATION

MAIL TO: MT. AUBURN HOSPITAL/MEDICAL RECORDS DEPARTMENT
330 MT. AUBURN STREET, CAMBRIDGE, MA 02138
ATTENTION: KATIE

PLEASE MAIL THIS FORM BACK TO THE ADDRESS ABOVE or E-MAIL TO MAHBILLING@MAH.HARVARD.EDU
******PLEASE NOTE THAT CORRECTIONS CANNOT BE MADE OVER THE PHONE******

If you have any questions regarding this form, please call (617) 499-5090 Monday through Friday, between the hours of 8:30 a.m. and 4:30 p.m.

TO BE COMPLETED BY PATIENT:

Financial Number ____

Wrong Information	**Correct Information**
Name: ____ (Last, First, Middle)	**Name:** ____ (Last, First, Middle)
Date of Birth: ____________________________________	**Date of Birth:** ____________________________________
Last 4 Digits of SS#: ______________________________	**Last 4 Digits of SS#:** ______________________________

Other Information:

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Please make the necessary corrections to my medical record.

Patient Signature: ____ **Date:** _______________________

Print Name: ____

(FIRST) **(MIDDLE)** **(LAST)**

Phone Number: ____