Associated Eye Care Patient Record Amendment Request Form

HIM Fax # 651-275-3032
HIM Email- HIM@associatedeyecare.com

Instructions: Patients or legal guardians should use this form to request a change to their legal name or gender marker. Please return this form to the front desk or Fax or Email it to our Health Information Management (HIM) department along with the required supporting documentation.

1. Current Patient Information (as it appears now)

- **Current Legal Name:** _____
- **Date of Birth:** _____ **Patient ID/MRN:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

2. Requested Update(s)

Please check all that apply:

☐ **Legal Name Change** (Marriage, Divorce, Adoption, Court Order)

- **New Legal Name:** _____

☐ **Legal Gender Marker Update** (M, F, or X)

- **New Legal Gender:** _____

☐ **Preferred Name** (Note: Does not require legal documentation)

- **Preferred Name:** _____
- **Preferred Pronouns:** _____

3. Supporting Documentation Attached

*To update **Legal Name** or **Gender**, please attach a copy of one of the following:*

- ☐ **Government Issued Identification** (Gender can be self-designated in MN as of 2026)
- ☐ **Certified Court Order** (for Name Change or Gender Recognition)
- ☐ **Amended Birth Certificate**
- ☐ **Adoption Decree or Adoption Certificate** *(for legal name changes associated with adoption)*
- ☐ **Marriage Certificate / Divorce Decree** (for marital name changes)
- ☐ **Physician's Letter** (Certifying appropriate clinical treatment for gender transition)

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4. Patient Acknowledgment & Signature

I understand that:

1. If this information is not also updated with my **Insurance Carrier**, insurance claims for my visits may be denied.
2. I am responsible for notifying my insurance company of these changes.
3. This amendment will become a permanent part of my medical record.

☐ Yes ☐ No I attest that I have notified my insurance company of my names and/or gender markers

Patient Signature: _____ **Date:** _____
(Parent/Guardian signature required if patient is under 18)

Internal Use Only

- **Date Received:** _____ **Received By:** _____
- **Documentation Verified:** ☐ Yes ☐ No **Scanned to Chart:** ☐ Yes ☐ No
- **Provider Notified:** _____ **EMR Updated Date:** _____