

**TREASURE VALLEY PEDIATRICS  
 NOTICE OF PRIVACY PROVISIONS  
 EXHIBIT B  
 Medical Information Request**

I hereby request Treasure Valley Pediatrics, PA amend the health care information maintained on the following patient:

Patient Name: \_\_\_\_\_

Patient Birthdate: \_\_\_\_\_

Patient SSN: \_\_\_\_\_

My relationship with the patient is:

Self       Parent       Guardian       Attorney-In-Fact

Other: \_\_\_\_\_

The individual documents I wish to reflect this amended information are the following:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I would like the information to say (please continue on additional sheets if necessary):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I would like the information amended for the following reason(s) (again, please continue on additional sheets if necessary):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Date

MD Review	<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Signature _____
Date _____			
PC Review	<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Signature _____
Date _____			
Board Review	<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Signature _____
Date _____			
Medical Rec	<input type="checkbox"/> Chart Amended	<input type="checkbox"/> No Action Taken	Signature _____ Date _____