

## Request to Amend Records Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name(First, MI, Last)	Client Date of Birth
Client Home Address	
Client Mailing Address (if different)	
Client Telephone	
Requestor Name (if different than client)	
Requestor Telephone Requesto	or Fax Number (optional)
Please list where you would like us to send our res	sponse to your request.
Name	
Address	
The information that the Department has about me that I believe is wrong or not complete:	
I would like the following corrections made to my information:	
The Department will notify you in writing if we are unable to respond to your request within 10 days.	
If this request is being made by someone other than the subject of the information, please describe and provide documentation of your authority to request an amendment to that person's information	
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Your signature Date	e requested
Your signature must be notarized if you submit this request by fax, mail or e-mail and we cannot verify it with information already on file.	
I,, being a Notary Public, c	do hereby
certify that on this dayofof, 20 the above individual, having been first duly sworn, appeared before me and	
the foregoing document.	O ID Provided O Form Complete
Signature of Notary Public	Authority:
	o Accessing own records
Notary Public residing at	O Documentation Attached
My commission expires on	O Not Required