MEDICAL RECORD NAME-CHANGE NOTICE

Employer_____

Medical Provider _____

Group no. _____ Member ID no. _____

Please be advised that the following client has had a change of name:

Current Name on Record _____

Date of Birth _____ Social Security no. _____

Memo (optional) _____

Please change the current name on your records to reflect the information below:

New Name _____

Address _____

City _____ State _____ Zip Code _____

☐ This also reflects a change of address (check if applicable)

I authorize the above-referenced record change. If there are any additional forms to fill out, please send them to me. If there are any questions regarding this change, please call me at telephone number _____. Thank you for your assistance.

Sincerely,

_____ _____

Signature Print Name

_____

Date

Enclosure: Photocopied Certificate of Marriage