Legal Name Change Request

Health Information Management Dept. Phone (202) 476-5267
111 Michigan Avenue, NW Fax (202) 476-2270
Room 1170.2
Washington, DC 20010
HIMinquiries@childrensnational.org

For Office Use Only:

__________________________________
Medical Record #

I, the undersigned, hereby authorize Children’s National Medical Center to change my child’s name

FROM:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
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</thead>
<tbody>
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</table>

TO:

<table>
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<tr>
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</thead>
<tbody>
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</table>

I, do hereby, declare that I am the parent or legal guardian and am responsible for the legal name with regard to the said patient.

____________________________________  __________________________
Signature of Parent or Legal Guardian  Date

____________________________________  __________________________
Phone Number  Email Address

Name Change Requirements:

One of the following documents (depending on the circumstances) should accompany this form and be returned to the Health Information Management Department:

1. Birth Certificate
2. Final Adoption Decree*
3. Marriage Certificate
4. Court Order
5. Valid Passport

*Not optional for Adoption Name Changes