Legal Name Change Request

Health Information Management Dept.
111 Michigan Avenue, NW
Room 1170.2
Washington, DC 20010
HIMinquiries@childrensnational.org

Phone (202) 476-5267
Fax (202) 476-2270

For Office Use Only:

_____
Medical Record #

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

FROM:

_____

First Name | Middle Name | Last Name | Date of Birth

TO:

_____

First Name | Middle Name | Last Name | Date of Birth

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

-NCRF-