Legal Name Change Request

Health Information Management
111 Michigan Ave NW
Washington, DC 20010
Room 1170.2

Phone 202-476-5267
Fax 202-476-2270

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

*Not optional for Adoption Name Changes

For Office Use Only:

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Medical Record #