Form to Request Amendment
to Health Information Retained in Designated Record Sets

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:____-____-____ SS#:____-____-____ MEDICAL RECORD #:_____
MO DAY YR

ADDRESS:_____ CITY:_____STATE:____ZIP:_____

DAY PHONE:_____ EVENING PHONE:_____

ENTRY TO BE AMENDED:

DATE:_____ TYPE:_____

Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, specify:

NAME:_____

ADDRESS:_____ CITY:_____STATE:____ZIP:_____

I understand that I will receive a copy of this Form and that my request will be processed within 60 days or be informed of the need for an extension of not more than 30 days to process the request. I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement disagreeing with the denial which must be contained on not more than one handwritten or typewritten page of at least 10-point font. All information relative to my request for amendment will be linked to my records and disclosed to anyone for whom I authorize disclosure of information relative to the amendment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE RECEIVED: AMENDMENT: ❑ Accepted ❑ Denied

If denied, reason for denial is:

- ❑ Information was not created by this organization
- ❑ Information is not a part of patient's designated record set
- ❑ Information is not available to the patient for access as required by federal law
- ❑ Information is complete and accurate

Comments of healthcare practitioner:

_____

_____

_____ _____ _____
SIGNATURE OF PRACTITIONER DATE TITLE