Request for Amendment to Patient Record

Forward this request to Privacy Officer or Office Manager

Patient Name: ____DOB:____________
Patient Address: ____
City-State, Zip: ____
Requestor (if other than patient):____
Legal Authority of Requestor: (attached necessary documentation such as power of attorney)____
Home Phone: ___________ Work Phone: _____________

Provide detailed information about the Requested Amendment: (attach an additional page if more room is needed for description)

Date of record entry (office visit, lab test, etc.):____________________________
Description of information:____
____
____
____
____
Reason for Request:____
____
____
____
Amendment requested:____
____
____
____
____

Provide names and addresses of recipients of subject information you would like notified of the amendment if accepted: (doctors, hospitals, pharmacists, others)

1. Name: ____
   Address: ____
   City-State, Zip: ____

2. Name: ____
Address: ____
City-State, Zip: ____

3. Name: ____
Address: ____
City-State, Zip: ____

I understand my record may or may not be amended and if I request this amendment request may be made a part of my medical record.

____ ________________

Signature Date

For Health Care Provider Use Only:

Date Received:________________By:____________________________________

☐ Amendment Accepted

☐ Amendment Declined

If denied, provide reason(s):

☐ Information is accurate

☐ Information not created by this office. Patient notified of how to contact originator.

☐ Prohibited from viewing (164.524). Explain in comments.

☐ Requestor not authorized

☐ Information not part of designated medical record set

☐ Other - Explain in comments.

Comments:

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____
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____

Reviewed by:____________________________________ Date:_______________

Date requestor notified of decision and options: ___________________________