[NAME OF PRACTICE]

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

You have a right to request an amendment of your protected health information. Please see Notice of Privacy Practices or contact [Name of Practice] Privacy Official at [Telephone Number of Practice] for information.

Please submit this form to: [Name of Privacy Official], Privacy Official
[Name of Practice]
[Address of Practice]

Your Name ________________________________

Address ________________________________

Daytime telephone number ________________________________

Please select one:

_____ I am a patient of Covered Entity.

_____ I am the personal representative of a patient of Covered Entity (*please attach proof of personal representative status*).

I would like to request an amendment to the following information:

____
____
____

The information should be amended in the following manner:

____
____
____

I believe this information should be amended because (required):

____
____
____

Please Read Carefully and Sign

I understand that [Name of Practice] will agree to my requested amendment unless it may deny the request under applicable law.

____ ________________________________

By: Date

Please note: Applicable law requires us to respond to you within 60 days after receiving your request, unless we send you notification that we will need an additional 30 days to respond.