[NAME OF PRACTICE]

GRANT OF REQUEST FOR AMENDMENT

Dear _____:

We received your request for amendment of your medical records on _____, 20___.

We have agreed to comply with your request. Accordingly, we will append or link the corrected information to the medical or health records in our possession.

If you like, we will notify persons you believe have received the medical or health information that is the subject of your amendment request. Please fill out and return the enclosed form listing the names and, if known, addresses, of those persons or entities. Please note that you must sign the form, giving us written permission to disclose this amendment information to the people you have listed.

Please call us at [Practice Telephone Number].

Sincerely,

[Name of Privacy Official], Privacy Official
[Name of Practice]

Enclosure

[NAME OF PRACTICE]

PERSONS OR ENTITIES TO BE NOTIFIED OF AMENDMENT

I authorize [Name of Practice] to notify the persons or entities listed below, of the amendment Covered Entity has made to my medical or health information (at my request).

NAME OF PERSON OR ENTITY	ADDRESS
_____	_____
	_____
	_____
_____	_____
	_____
	_____
_____	_____
	_____
	_____

(Please attach additional pages, if needed.)

_____
Print Name

_____
Sign Name

_____
Date

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