Request For Correction and Amendment of Protected Health Information

NOTE: Complete One Form Per Patient

PATIENT INFORMATION:

______________________________ ______________________________

Name **Date of Birth**

____

Street Address

______________________________ ______________________________

Email Address **Phone Number**

1. **Describe the information you want corrected/amended including dates:**

   ____

   ____

   ____

2. **What should the information say to be accurate or complete?**

   ____

   ____

   ____

3. **Do you know anyone who may have received or relied on the information in questions?**

   ____

   ____

   ____

4. **If the amendment is accepted, would you like to share the amendment with individuals who may have received this information?** ☐ **Yes** ☐ **No**

   If yes, please specify the name and address of the organization (s) or individual (s).

   ____

   ____

   ____

You will receive a written response within 60 days of receipt of this request. The practice may request in writing an additional 30 extension as permitted under federal law.

______________________________ ______________________________

Signature of Legal Representative/Patient 18 yrs or older **Date**

______________________________ ______________________________

Printed name of Legal Representative/Patient 18 yrs or older **Relationship to Patient**