Request For Correction and Amendment of Protected Health Information

NOTE: Complete <u>One</u> 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** _____