

2. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services) _____

3. What is your reason for making this request? _____

4. How is the entry incorrect, incomplete, or outdated? _____

5. What should the entry say to be more accurate or complete? (Please be as specific as possible) _____

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?
_____ yes _____ no

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

Signature of patient or patient's Personal Representative _____
Date of Signature: _____

FOR THE PRACTICE USE ONLY

Amendment has been: ___ Accepted ___ Denied

If denied, check the reason for denial:

- ___ Protected Health Information was not created by this Practice
- ___ Protected Health Information is not part of the patient's designated record set
- ___ Protected Health Information is accurate and complete

Comments _____

Signature of Practice Manager/Medical Director: _____

Date of Signature: _____