



AMENDMENT REQUEST

Purpose: This form is used for an individual's request to amend the information in designated record sets that we maintain or that our business associates maintain for us.

SECTION A: Individual requesting records amendment.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Medical Record Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to request us to amend your information. We may decline your request if the information is not part of our designated record sets, or if we did not create the information, or if we believe the information is complete and accurate or would not be available under the right to access at 45 CFR § 164.524. Submit the supporting documents for your request.

SECTION B: Information to be amended.

Please specify the records you wish to amend and the amendment you wish to make: _____

Please state the reason for the amendment: _____

Please list the name and address of each person or entity who you want us to notify of the amendment, should we agree to make the amendment you request.

INDIVIDUAL'S SIGNATURE - YOU ARE ENTITLED TO A COPY OF THIS REQUEST

_____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Physician Signature – Please explain your answer.

As the provider of the corresponding patient in this application, answer with an X if you agree or disagree with the amendment requested.

YES NO

If your answer is no, please explain the reason of your answer.

Firma: _____

Fecha: _____