

## Patient Request to Amend Medical/Dental Record

You have the right to request an amendment to your protected health information. If you would like to request an amendment to your protected health information, please complete the form below and hand it to the Medical Records Supervisor/Privacy Officer.

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Patient Medical Record Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Date of Amendment Request: \_\_\_\_\_

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (This statement is limited to a total of 250 words so an additional page can be used.)

\_\_\_\_\_

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name/Address: \_\_\_\_\_

\_\_\_\_\_

Name/Address: \_\_\_\_\_

\_\_\_\_\_

Note: If you have additional names, please attach an additional sheet to this page.

I understand that by listing the name(s) and address (es) of other organizations on this Amendment form, I am asking (Facility Name), (Facility) to disclose the requested amendment to these organizations. I thereof give specific permission to (Facility Name) to disclose the amendment to these organizations, and I understand that (Facility Name) will take reasonable steps to send the requested amendment to these organizations.

In addition, I understand (Facility Name) may be required to send this amendment to Business Associates or other organizations that (Facility Name) identifies as needing the amendment. I thereof give specific permission to (Facility Name) to send the requested amendment to these organizations identified by (Facility Name) as needing the amendment.

I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be no longer available to act on this amendment request and present to (Facility Name) evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, (Facility Name) may deny the amendment request.

By signing below, I fully acknowledge and agree to the above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_