

Your Practice Name Here

Medical Record Amendment Request Form

I, _____, request that MEDICAL PRACTICE NAME change/amend my medical record because:
(*Explain what is to be changed/amended and why.*)

For my medical record to be more complete/accurate, it should say:

Patient signature: _____

Printed name and date of birth: _____

Date of request: _____

Privacy Officer Action/Comments:

Action must be taken within 60 days of the receipt of the request

____ Request approved without change.

____ Request denied for the following reason:

___ Information is not part of your designated record set.

___ The information is accurate and complete.

___ Under HIPAA you are restricted from accessing or amending this information.

____ Practice requests a 30-day extension to respond due to: _____

Signature of Privacy Officer _____

On _____ (date) _____ (name) filed a statement of disagreement to the Practice's denial of their request for amendment dated _____. The Practice responds to this statement of disagreement as follows:

Signed by: _____ Date: _____