CLIENT REQUEST FOR AMENDMENT TO PROTECTED HEALTH INFORMATION

CLIENT'S NAME: ______________________________

CLIENT'S ADDRESS: ______________________________

CLIENT'S DATE OF BIRTH: ______________________________

PLEASE COMPLETE THIS FORM ONLY IF YOU HAVE REVIEWED YOUR HEALTH INFORMATION AND WOULD LIKE TO MAKE A CHANGE OR AN AMENDMENT TO IT. EXPLAIN HOW THE INFORMATION ENTERED ON YOUR HEALTH RECORD IS INCORRECT OR INCOMPLETE. INCLUDE WHAT THE INFORMATION SHOULD SAY TO BE MORE ACCURATE OR COMPLETE.

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DOES THIS AMENDMENT NEED TO BE SENT TO ANYONE. IF SO, PLEASE INDICATE THE NAME AND ADDRESS OF THE INDIVIDUAL OR ORGANIZATION.

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PLEASE SIGN AND DATE THE REQUEST. YOU WILL BE NOTIFIED, IN WRITING, WHICH PORTIONS, IF ANY, OF THE AMENDMENT REQUEST WILL BE HONORED OR DENIED. IF THERE IS A DENIAL TO THE REQUEST, A WRITTEN EXPLANATION WILL BE PROVIDED.

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SIGNATURE DATE

RETURN TO THE COMPLIANCE OFFICER

APRIL 2012