REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

I hereby request that my Protected Health Information be amended as described below:

Patient Name (Print): _____
Last First MI

Date of Birth: _____/_____/_____

Address (including Suite/Apt. Number if applicable):

_____

_____

_____

Telephone Number (preferred contact number):

_____

Please answer the following questions. You may attach a separate page if more space is needed.

What information would you like to amend?

_____

_____

_____

_____

How do you believe the information should be amended?

_____

_____

_____

_____

Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request.

_____

_____

Is this request being made because of an emergency or other urgent situation? If so, please describe the nature of the emergency or urgency below and the date you need the information amended. AdvantageCare Physicians cannot guarantee that it will meet your deadline, but AdvantageCare will do its very best to accommodate reasonable requests.

What entities should AdvantageCare provide information about this requested amendment if accepted?

What entities should AdvantageCare provide information about this requested amendment if it is denied?

By signing below, I am requesting that AdvantageCare amend my health information as I have explained above and provide the entities identified above information concerning the requested amendment and whether it was accepted or denied.

Signature of Patient or Personal Representative

Date

Print Name of Personal Representative

Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

AdvantageCare Physicians
Privacy Officer
55 Water Street, 12th Floor
Rm 12H92
New York, NY 10041

For AdvantageCare Use Only:

Date Received: (MO/DY/YR) ____/_____/_____

Disposition of Request: ____ GRANTED _____ DENIED ___ PARTIALLY DENIED

Patient Notified in Writing: (MO/DY/YR)___/___/_____

Name of HIM Staff Member Processing This Request: