Date Received__________

Initials of Privacy Officer__________

Request for Amendment to Patient Record

Section A1: Patient to complete the following information.

Date:______________________Medical Record Number:_______________________________________

Patient Name:____ DOB: __________________

Street Address: ____

City, State, Zip:____

Home Phone: ______________ Work Phone: ______________ Email address: ______________________

Requestor (if other than patient): ____

Legal Authority of Requestor (attach documentation such as power of attorney): ___________________

Section A2: Patient to complete the following information.

Provide detailed information about the requested amendment. Attach an additional page if more room is needed for description.

I hereby request that OrthoSC, LLC amend the following in my Designated Record Set (check all that apply):

_______Medical Records _______Billing Records

Dates of information to be amended (i.e., date of visit, treatment or other healthcare services):

____

Description of Information: ____

____

____

____

The info is incorrect or incomplete in the following manner: ___________________________________

____

____

____

I request this amendment for the following reasons: ____

____

____

____

This information should be amended as follows:____

____

Section A3: Patient to complete the following information.

Provide names and addresses of recipients of subject information you would like notified of the amendment if accepted: (doctors, hospitals, pharmacists, other)

1. Name:____
   Address:____
   City, State, Zip:____________________________________
2. Name:____
   Address:____
   City, State, Zip:____________________________________
3. Name:____
   Address:____
   City, State, Zip:____________________________________

I understand that OrthoSC, LLC may or may not supplement my record with an addendum based on my request. I also understand that OrthoSC, LLC is not able to alter the original documentation in a record under any circumstances. Regardless of whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information.

Patient or Personal Representative Signature: ________________________Date: __________

Print Name:________________________Personal Representative's Title:________________

Section B: OrthoSC, LLC to complete the following information.

Date Received: ______________Received By: ________________________________

Request for amendment had been:

☐ **Accepted**

☐ **Denied**

If denied, provide reason(s):

☐ Information is accurate and complete.

☐ Information not created by OrthoSC, LLC. Patient notified of how to contact originator.

☐ Prohibited from viewing (164.524). Explain in comments.

☐ Requestor not authorized.

☐ Information not part of designated medical record set.

☐ Other – Explain in comments.

Comments:____

____

____

____

Notice to Patient/Others

Patient and/or others notified of determination via one or more of the following (check all that apply):

☐ *Amendment Acceptance Letter* sent to patient on__________________(date).

☐ *Amendment Acceptance with Consent to Notify* sent to patient on _______________(date).

☐ *Notification of Amendment* sent to identified persons pursuant to patient authorization on ____________(date)

Signature of Privacy Officer:____ Date: ___________________

Print Name:_____________________________________