SIGNATURE MEDICAL GROUP

PHYSICIANS MAKING A DIFFERENCE

SIGNATURE MEDICAL GROUP, INC.

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Date Received: _____ Approved_____

Denied _____

Patient Name:	Date of Birth	Patient Medical Record Number:
Patient Address:		
Date of Entry to be Amended/Corrected:	Type of Entry to be Amended:	

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Please provide the documentation you consider necessary to correct the entry or for it to be more accurate or complete. Use additional sheets if needed and attach to this form.

_____

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_____

If you agree, Signature Medical Group, Inc. will make a reasonable effort to provide the amendment to other persons who Signature Medical Group, Inc. knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.
I agree to allow Signature Medical Group, Inc. to release any amended information to individuals or entities as described above.

Would you like this amendment sent to anyone else who received the information in the past? ❑ Yes ❑ No

If yes, please specify the name and address of the organization(s) or individual(s).

_____

_____

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	DATE
(If Personal Representative, state relationship to patient)	
AMENDMENT HAS BEEN ❑Accepted ❑ Denied	

IF DENIED, CHECK REASON FOR DENIAL

❑ PHI is not part of the patient's record
❑ Record is not available to the patient for designated record set inspection under Federal law
❑ Signature Medical Group, Inc. did not create record

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❑ Record is accurate and complete

COMMENTS OF HEALTHCARE PROVIDER (If applicable)

_____

_____

_____

_____
SIGNATURE OF HEALTHCARE PROVIDER (If applicable)

_____ _____
TITLE DATE