High Rock Internal Medicine, P.A.
Amendment Request Form

I, _____ hereby request that an amendment be added to my medical records by **High Rock Internal Medicine, P.A..** Under federal law 104-191, also known as HIPAA, I am entitled to request such an amendment of my personal medical records upon written request.

Please describe the amendment(s) you wish added to your medical records and the reason why:

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Policies and Limitations on Amendments to Personal Medical Records

- ❑ Under federal law, we may accept your request for amendment(s) to your medical records, or we may deny your request. If we deny your request, we must include a copy of your disagreement in your medical records, along with your request.
- ❑ We are only required to amend information that is in your "Designated Record Set", which is medical and billing information that we created and maintain in our facility, and which is used to directly make decisions about your healthcare and treatment. If the information you wish to have amended was created by another entity, you should contact that entity to have that information amended.
- ❑ The following kinds of information are exempted from amendment:
    - Items not maintained in legal health records
    - Education records exempt from HIPAA
    - Psychotherapy Notes
    - Data exempted by the Clinical Lab Improvements Act
    - Data involved in criminal, civil, or administrative actions
    - Records put together in anticipation of legislation
- ❑ Under federal law, we must act on your request for amendment(s) within sixty (60) days of your initial request, by either amending your medical records or by providing you with a written denial of your request. We may take an additional thirty (30) days to act on your request, but only if we provide you with a written notice of the reason for the delay and an expected completion date.
- ❑ If we deny your request for amendment, we will provide you with a written notice of the reason(s) for the denial.

- You have the right to file a "Statement of Disagreement" with the denial.
- You have the right to file a complaint with the US Department of Health and Human Services over the denial of amendment.

Patient Name: _____

Address: _____

_____

_____

Telephone: _____

Email: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:			
Date Received:		Time Received:	
Action(s) Taken:			
Records Amended:			
Approved By:			