Medical Record Amendment/Correction Request Form

Medical Record Amendment/Correction Request Form

Patient Name: ______________________________ Date of Birth: ___________ Phone Number: ________________

Address: _____________________________ City: ____________________ State: _____ ZIP Code: ____________

Medical Record Amendment/Correction requested by:

Name: _____________________________ E-mail: _______________________ Phone Number:_______________

Amendment/Correction Request Details

Type of Request: □ Amendment □ Correction

Date(s) of Service:____

Description of Information to be Amended/Corrected:

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Reason for Amendment/Correction:

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Patient Authorization

I, ______________________________, request that Quinn Orthopedic Physical Therapy amend/correct my medical record as described above. I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for the purpose beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that I may revoke this authorization at any time by providing written notification to Quinn Orthopedic Physical Therapy.

The revocation will be effective on the date it has been received and processed by Quinn Orthopedic Physical Therapy. I understand that the revocation does not apply to actions taken in reliance upon the authorization prior to the effective date of the revocation. I also understand that I do not have to sign this authorization to receive treatment, pay, or to enroll or be eligible for benefits. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: ____ Date:_______________

Name: ____________________________________ Relationship to Patient: ______________________________

If Signed by Representative (Signature of Witness):____

For Office Use Only

Received by: ____________________________ Date Received: ____________ Date Completed: ______________