TEXAS SPORTS REHAB

Request for Amendment of Protected Health Information

I _____ who resides at _____

in the city of _____ in the state of _____ hereby request that

the following item(s) in my medical record, or the record of my minor child be amended / corrected as follows:

_____ _____

Patient Name Date of Birth (For Identification Purposes)

_____ _____

Date of Entry to be Amended/Corrected Type of Entry to be Amended/Corrected

Please explain how the entry is incorrect or incomplete. What should the entry state in order to be more accurate or complete? (Attach additional page(s) as required)

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed information in the past? If so, please specify the name and address of the organization of individual. Please remember that the requested change **is subject to approval**.

Name: _____
(Physician, Hospital, Clinic or Other Health Care Organization)

Address: _____

City, State, Zip: _____

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature (Or Guardian, If A Minor) Date of Birth (For Identification Only)

For Office Use Only Correction / Ammendment has been: ☐ Accepted ☐ Denied

If denied, please check reason for denial:

- ☐ PHI was not created by this organization
- ☐ PHI is not available to the patient for inspection as required by federal law.
- ☐ PHI is accurate and complete
- ☐ PHI is not part of patient's designated record set

Comments of provider: _____

_____

_____ _____

Signature of Provider Date