PATIENT AMENDMENT REQUEST FORM

Section A- Patient Information	
Patient Name (First, Middle and Last)	Ohio ENT and Allergy Acct #
Current Address	City State Zip
Phone Number ( )	Date of Birth / /

SECTION B – Description of health information you are requesting to be amended:

1. Description of information to be amended: *(e.g. medical record, lab results)*

_____

_____

2. Date(s) of the information to be amended: *(date of office visit, date of procedure, date of other services)*

_____

_____

3. What is the reason for this change request?

_____

_____

4. What change to the documentation do you believe would improve accuracy of your information?

_____

_____

5. Do you know of anyone who may have received or relied on the information in question?
Yes _____ No _____ If yes, who?_____

SECTION C – Understanding your right to request an amendment of your health information:
I understand I have the right to request an amendment to my health information at Ohio ENT & Allergy Physicians. I understand Ohio ENT & Allergy Physicians is not always required to make the amendments I have requested; however, my request for amendment will be carefully reviewed and amendments will be made when warranted. I understand that I will receive a written response within 60 days. If Ohio ENT & Allergy Physicians denies my request (in whole or in part), I will receive an explanation of why it was denied and what my options are.

Signature of Patient/Patient's Personal Representative: _____ Date:_____

Printed Name: _____ Relationship, if not the patient _____

Fax to: 614-255-0558 or email ROI@ohpin.com

FOR INTERNAL USE ONLY
Amendment has been: Accepted _____ Denied _____
If denied, the reason for denial

Signature of staff person: _____ Date: _____

Print Name and Title: _____