PATIENT REQUEST TO AMEND PERSONAL HEALTH INFORMATION

To request an amendment of your patient records, please complete and return this form to:

Attn: Tiffany Neale, Privacy Officer
3653 N. Locust Grove Road
Meridian, Idaho 83646
fax: (208) 939-9811
e-mail: tneale@meridianpediatrics.com

Although you may request an amendment, we may deny the request if, e.g., we determine that the original record is correct. If we deny your request for amendment, you have a right to have your request for amendment attached to your medical record upon your request.

To be completed by patient or personal representative

Date of request for amendment: ______/______/_____

Patient: ____________________ Date of Birth: ____/____/____
Address: ____________________
____
Telephone: ____________________

Describe record to be amended (attach copy if available): Date of Record: ____/____/____

____

Describe the amendment requested, or make requested changes on copy of record:

____
____

Reason for amendment (e.g., why do you think the original record is not accurate**?):**

____
____

f the request is accepted, identify those entities (including names and addresses) who received the original record and need the amendment (attach separate paper as necessary):

1. ____________________
2. ____________________
3. ____________________

I certify that I am the patient identified above or that I am legally authorized to make health care decisions for the patient. If Meridian Pediatrics accepts the request for amendment, I agree that Meridian Pediatrics may notify the entity(ies) identified above of the amendment.

Name: ____________________ Date: ____/____/____
Signature: ____________________
Telephone: ____________________

If personal representative, describe relationship to patient or authority:

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