UROLOGY CENTER
OF COLUMBUS, L.L.C.

Request to Amend Patient Records

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Street City, State Zip

I request that the following medical record information be amended (*attached a separate document if needed*):

_____

_____

_____

Reason for the requested change:

_____

_____

_____

I understand that you will review my request to amend records and provide a written determination within 60 days. I also understand that Federal Regulations may not allow information to be amended under certain circumstances specified by HIPPA Privacy Rules 45 CFR 164.526. If the request is denied, I understand that I may submit a written statement explaining my disagreement with the decision, which statement will be included in my medical records, along with any response from the practice.

If the amendment is approved, in whole or in part, I understand the practice will make the appropriate amendment to my records and also is required to make reasonable efforts to inform and provide the amendment within a reasonable time to other entities or practices who received the PHI.

_____ _____
Patient Signature or Personal Representative Date

Office Use Only

- ❑ **We hereby accept this request.**
- ❑ **We hereby deny this request.**

_____
Practice Representative (Type/Print)

_____
Practice Representative Signature

_____
Date