MIDLANDS orthopaedics & NEUROSURGERY

Request for Amendment to Patient Record

Section A1: Patient to complete the following information.

Date: _____ Medical Record Number: _____

Patient Name: _____ DOB: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Requestor (if other than patient): _____

Legal Authority of Requestor (attach documentation, e.g., POA):

_____

Section A2: Details of requested amendment.

I hereby request an amendment to my Designated Record Set (check all that apply):

☐ Medical Records ☐ Billing Records

Dates of information to be amended (e.g., date of visit, treatment):

_____

Description of Information:

_____

_____

_____

_____

The information is incorrect or incomplete in the following manner:

_____

_____

_____

_____

I request this amendment for the following reasons:

_____

_____

_____

_____

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This information should be amended as follows:

_____
_____
_____
_____

Section A3: Persons to notify if the amendment is accepted (list recipients).

1. Name: _____

Address: _____

City, State, Zip: _____

2. Name: _____

Address: _____

City, State, Zip: _____

3. Name: _____

Address: _____

City, State, Zip: _____

I understand that I will be notified of the decision to accept or deny my amendment request within 60 days of its receipt by the practice. If accepted, the amendment will be added as an addendum to the original entry and reasonable efforts will be made to notify recipients I identify. In all cases, this amendment request and corresponding decision will become a part of my permanent medical record and will be provided as such in response to any authorized requests for release of my Protected Health Information (PHI).

Patient or Personal Representative Signature: _____

Date: _____ Personal Representative's Title: _____

Print Name: _____

Amendment Request Form Submission Options:

- Via the patient portal: select message type Record Restriction and attach the completed form.
- Via mail: Attn: HIPAA Specialist | Midlands Orthopaedics & Neurosurgery | 1910 Blanding Street, Columbia, SC 29201
- Via email: monhipaa@midorthoneuro.com | Please note that email is not a secure communication method unless you are able to encrypt your message and/or the attached form before sending. While we accept submission via email, we are not responsible for any breach of PHI in transit from you to the practice.

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Section B: For Office Use Only

Date Received: _____ Received By: _____

Request for amendment has been: ☐ Accepted ☐ Denied

If denied, provide reason(s):

☐ Information is accurate and complete

☐ Information not created by entity; patient notified how to contact originator

☐ Prohibited from inspection under 45 C.F.R. §164.524

☐ Information not part of designated record set

☐ Other – see comments

Comments: _____

_____

_____

_____

Notice to Patient/Others (check all that apply):

☐ Amendment Acceptance Letter sent to patient on: _____

☐ Acceptance with Consent to Notify sent to patient on: _____

☐ Notification of Amendment sent to identified persons (per patient authorization) on: _____ (date)

HIPAA Specialist Signature: _____ Date: _____

Print Name: _____