Orlin & Cohen Medical Specialists Group

PATIENT REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

Patient Name: ____ SS# ______________________________

Street Address: ____ City: ______________________________

State: _______________ Zip Code: _____________________ Date:______________________________

As provided by the Health Insurance Portability and Accountability Act and federal regulations, patients have the right to request an amendment or correction to their protected health information. Patient requests will be acted upon by Orlin & Cohen Medical Specialists Group within 60 days of the date the request is received. However, if Orlin & Cohen Medical Specialists Group is unable to act on the request within such time frame, I may provide a written notice within 60 days explaining the reasons for delay and the date by which it will act, which shall be within 90 days of the date the request is received. Once your request has been acted upon, your request for amendment will either be granted or denied. If denied, you will be notified in writing of the reasons for denial. Please refer to our Notice of Privacy Practices and other policies for a complete statement of your rights.

Please indicate specifically what information you wish to have amended and what your information should say to be more accurate or complete. Please also indicate the reasons for requesting such amendment. You may attach a separate sheet if necessary.

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Please indicate whether there is anyone to whom you would like us to notify of the amendment to your protected health information. If so, please provide us with the name of the individual or organization, their address and telephone number.

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Patient Signature____

FOR OFFICE USE ONLY

Date Amendment Request Received__________________

Name of staff member:___________________________

Request Accepted ________ Denied_________________

If denied, specific reason: ____