
Asheville Neurology Request for Amendment to Patient Record

Forward this request to Privacy Officer or Office Manager

Patient Name: _____ DOB: _____
Patient Address: _____
City-State, Zip: _____
Requestor (if other than patient): _____
Legal Authority of Requestor: (attached necessary documentation such as power of attorney) _____
Home Phone: _____ Work Phone: _____

Provide detailed information about the Requested Amendment: (attach an additional page if more room is needed for description)

Date of record entry (office visit, lab test, etc.): _____
Description of information: _____

Reason for Request: _____

Amendment requested: _____

Provide names and addresses of recipients of subject information you would like notified of the amendment if accepted: (doctors, hospitals, pharmacists, others)

1. Name: _____

Address: _____

City-State, Zip: _____

2. Name: _____
Address: _____
City-State, Zip: _____

3. Name: _____
Address: _____
City-State, Zip: _____

I understand my record may or may not be amended and if I request this amendment request may be made a part of my medical record.

Signature Date

For Health Care Provider Use Only:

Date Received: _____ By: _____

Amendment Accepted

Amendment Declined

If denied, provide reason(s):

Information is accurate

Requestor not authorized

Information not created by this office. Patient notified of how to contact originator.

Information not part of designated medical record set

Prohibited from viewing (164.524). Explain in comments.

Other - Explain in comments.

Comments:

Reviewed by: _____ Date: _____

Date requestor notified of decision and options: _____