Treat MS

Amendment Request

Patient Name____Today's Date_______________________

Patient Address ____

City____State: _________ Zip________________

Last Four Digits of SSN___________________________ Date of Birth________________Phone________________________

Medical record number(s) / Account(s) ____

Date(s) of disputed entry(ies): ____

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In what documentation did you see this disputed entry: ____

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(1) Describe how the disputed documentation is incorrect and/or incomplete. **(2)** Write exactly what you think the documentation should state to be accurate and/or complete. If additional space is needed, use a separate sheet of paper and attach to this form. **DO NOT write on the back of this form.**

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If your request is accepted, a copy of the amended information will be sent to any persons who previously received this information. If there is anyone else you would like the amended information sent to, please provide the name of the organization/ individual and address below:

Name______________________________ Address ____

Name______________________________ Address ____

Signature below is acknowledgement I have read and understood the amendment request instructions and procedures that follow once I submit this request.

Patient's Legal Representative's Signature____Date ___________

Legal Representative's Printed Name______________________________________Relationship to Patient _______________

FOR OFFICE USE ONLY: (1) Request verified and processed by: Universal ID _________________________ Date ____________

(2) Request verified and processed by: Universal ID _________________________ Date ____________

Request has been: ☐ Granted ☐ Partially Granted ☐ Denied

Form of ID presented for verification: ☐ Driver's license ☐ Government ID ☐ Other (specify)

Amendment Request *(Continued)*

Patient instructions for requesting an amendment to your medical record.

1. You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete.

2. To request an amendment to your medical information, fill out the Amendment Request Form entirely.

3. You will be notified of the acceptance or denial of your request within 60 days of its receipt. If there is a delay, you will be notified in writing on a one-time 30 day extension. The notification will include a reason for the delay and the date by which the action will be completed.

4. If your request has been accepted and have authorized Treat MS to disclose any amended information, we will send copies of any amended or corrected information to the parties who previously received records and the one(s) you have indicated on the request form.

5. If your request has been denied, you have the right to submit a written statement of disagreement to Treat MS.

6. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. http://www.hhs.gov/ocr/privacy/index.html

7. The Amendment Request and any additional documents related to the request will become a part of your permanent medical record and may be disclosed to future requestors as it relates to the subject of the amendment.

8. Once the form is completed, you may mail, fax, or email the form to Treat MS.