REQUEST FOR AMENDMENT OR CORRECTION OF MEDICAL/HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: Street _____ Apt/Suite _____

City _____ State _____ Zip _____

Type of Entry to be Amended: _____ Visit note _____ Nurse note _____ Rx Information

_____ Patient history _____ Hospital note

How is the entry inaccurate or incomplete: _____

_____

_____

Specify the change to be made and explain why the new information will be more accurate or complete: _____

_____

PLEASE NOTE that this practice reserves the right to deny your request for a change, correction or amendment to the record. If your request is denied, the practice will provide a written explanation for the denial.

_____ _____

Patient or Legal Representative Signature Date

_____

Print name of Patient or Legal Representative

Request for change, correction or amendment has been:

_____ Accepted _____ Denied _____ Denied in part & Accepted in part

Patient/Legal Representative ____ has _____ has not been provided with a written explanation.

_____ for the practice.

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFOMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

_____ _____

City, State, Zip

I understand and agree that I am being allowed to inspect my original medical and health information records in the possession of this practice and that I will not remove, destroy or deface any part of the record during the inspection. However, I have been informed that I do have the right to request, in writing, that the record be changed or amended, but that the practice does have the right to deny my request.

I further understand and agree that I am financially responsible for the following fees associated with my request for a copy of the record: Copying charge is $1.00 for first page and .50 cents for subsequent page as provided by Oklahoma Statute, 79 O.S. 19. Postage will be reimbursed in full. There will be no other charges for the copying of my medical information.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print name of Patient or Legal Representative

Total charge for copy: $ _____ (_____ pages @ $1.00 for 1st page, .50 each page after)

Postage: $ _____

TOTAL CHARGE: $ _____