



REQUEST FOR CORRECTION/AMENDMENT OF HEALTH INFORMATION

Date Of Amendment Request: _____

Patient Name: _____

Date Of Birth: _____

SSN: _____

As a patient of Alliance Orthopaedics & Sports Medicine, P.C., you have the right under federal law to request an amendment to your protected health information. If you would like an amendment to your protected health information, please complete the form below.

Type Of Entry To Be Amended: _____

- Office Visit Note
- Nurse's Note
- Prescription Information
- Patient History

Please explain how the entry is inaccurate or incomplete

Please specify what the entry should say to be more accurate or complete

I understand that Alliance Orthopaedics & Sports Medicine, P.C. may be required to send this amendment to Business Associates or other organizations that Alliance Orthopaedics & Sports Medicine identifies as needing this amendment. I therefore give specific permission to Alliance Orthopaedics & Sports Medicine to send the requested amendment to these organizations.

By signing below, I fully acknowledge and agree to the above terms.

Signature of Patient Or Legal Guardian

Date

Print Name Of Patient or Legal Guardian

Signature Of Witness