STX SOUTHTEXAS DERM DERMATOLOGY

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REQUEST FOR AMENDMENT OF MEDICAL RECORDS

Patient Information

Patient Name: _____ Date of Birth _____

Phone Number: _____ Email: _____

Address: _____

Record to be Amended

Date of Service: _____ Provider: _____

Description of the record to be amended: _____

_____

Requested Amendment

Please describe how the record should be changed: _____

_____

_____

Reason for Request

Why do you believe this amendment is necessary? _____

_____

Supporting Documentation

☐ I have attached documents supporting this request and listed them as follows.

_____

Notification Request

If this amendment is approved, would you like us to notify other persons or organizations that may have received the incorrect information? ☐ Yes ☐ No

If yes, please list them: _____

_____

Patient Acknowledgment

I understand that:

- My request will be reviewed in accordance with applicable federal and state law.
- Approval of this request does not result in deletion or alteration of the original medical record. If approved, an amendment or addendum will become part of my medical record.
- I will receive a written response regarding this request.

Printed Name: _____

Signature: _____

Date: _____

Relationship to the patient (if not the patient): _____

HIPAA Notice

Under HIPAA, requests for amendment are generally reviewed within 60 days. If additional time is required, South Texas Dermatology may extend the review period once for up to 30 additional days. You will be notified in writing of any extension. Approved amendments become part of the medical record; the original record is retained and is not removed or deleted.

Office Use Only

Date Received: _____ Reviewed by: _____

☐ Approved ☐ Partially Approved ☐ Denied

Comments: _____

_____

_____

_____

Date Completed: _____ Response Sent: _____