flexogenix
NON-SURGICAL SOLUTIONS FOR AN ACTIVE LIFESTYLE

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____ *Medical Record Number:* _____

Date of Birth: _____ *Phone Number:* _____

Patient Address: _____

Treatment Dates:

_____

Type of Entry to be amended: _____

Date of Entry to be amended: _____

Please explain how the information is incorrect or incomplete. Include the information that you feel should be included in order to make the record more accurate or complete.

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

_____

_____

I understand that this amendment request will become a part of my designated record set. I also understand that this request is subject to the review of a medical provider who will use his/her professional judgment as to whether my record should be amended.

_____ _____ _____

Signature of Patient or Authorized Representative *Date* *Time*

If signing as authorized representative, describe authority to act for patient and submit documentation showing such authority: _____

FLEXOGENIX, INC. USE ONLY

Date request received: _____

Circle one: Accepted Denied

If denied, state reason for denial: _____

☐ Patient was informed of amendment or denial Means of Communication: _____

Signature of staff member: _____ *Date/Time:* _____

Staff Member (Print Name): _____

Signature of Healthcare Provider: _____ *Date/Time:* _____