SYRACUSE ORTHOPEDIC SPECIALISTS

Request To Amend Health Information

Patient Name: _____ **Date of Birth:** _____

Other Names Used (e.g. Maiden Name): _____

Patient Mailing Address: _____

I request to have my record amended. **Date of Record/Appointment Date:** _____

-

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page.

_____

_____

_____

_____

_____

_____ _____

Patient or legally authorized individual signature *Date*

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

We will review your request and respond within 60 days of receipt. A copy of your request will be added to your record. The amended record will be forwarded to prior recipients. We will also send the amendment to any additional parties you identify.

To be completed by Syracuse Orthopedic Specialists, PC:

Amendment has been:

Date received _____ □ Accepted □ Denied - Letter sent (date) _____

□ Review of this request has been delayed due to _____

□ Your request will be processed by the following date _____ (no later than 90 days after request).

If denied, check reason for denial:

□ This health information was not created by this organization.
□ This request does not pertain to the patient's medical and financial records.
□ By law, this health information is not available to the patient and cannot be amended.
□ The existing health information is accurate and complete.

_____ _____

Name of reviewing department or position Date