Patient Request for Amendment to Protected Health Information

I, the undersigned, am requesting an amendment to protected health information maintained by Orthopaedic Associates of Michigan. I understand that this request may be accepted or denied. I also understand that if this request is accepted the following actions may occur:

- I will be informed of the amendment's acceptance by mail.
- Any original information will remain in the record with the requested amendment or amended information.
- I may authorize a notification of the amendment to be sent to persons or entities identified by me.
- A copy of the amended information may be sent to entities that could be predicted to use the original information in a detrimental manner.

If the request is denied, the following actions may occur:

- I will be provided with a written denial explaining the reason for the denial by mail.
- I can submit a disagreement to the denial stating my reasons for the disagreement.
- I may receive a response (rebuttal) to my disagreement.

I understand that a copy of this request, an acceptance or denial, a copy of any disagreement, and any rebuttal will become a permanent part of the medical record along with the original information I sought to amend.

Patient name _____ **Date of birth** _____
(Please print)

Mail to Name and Address:

_____

_____

_____

Office use only

☐ Sent

Date Sent _____

Patient signature _____ **Date of request** _____

Requested Amendment

Date of appointment(s): _____ **Provider**: _____

I request the following information be added to my medical record:

_____

_____

_____

_____

_____

_____

Acceptance of Requested Amendment

☐ Your request to amend protected health information in the medical record has been accepted. This form serves as our notice to you of the acceptance. We will make the amendment to the medical record as you requested. Please note that the original information must still be maintained along with the amended information in the medical record as required by the Privacy Rule.

We will provide a copy of the amendment to persons or entities that you identify on this form. We will also provide a copy of the amendment to persons or entities that we identify in order to prevent them from using the original information, which in certain instances could be detrimental to your care.

Denial of Requested Amendment

☐ Your request to amend protected health information in the medical record has been denied. This form serves as our notice to you of the denial. We have attached a copy of the reason for the denial to this notice. Please note that a copy of your request and the denial will be maintained, along with the original information, in the medical record as required by the privacy rule.

You have the right to submit a written disagreement to our denial of your requested amendment. If you wish to submit a written disagreement, please mail it to:

Privacy Manager
Orthopaedic Associates of Michigan
1111 Leffingwell Ave. NE
Grand Rapids, MI 49525

After review of your disagreement, we will provide you with a written rebuttal if we decide to continue with the denial. As with the request and the initial denial, a copy of the disagreement and rebuttal (if applicable) will be maintained in the medical record as required by the Privacy Rule.

Please contact our Privacy Manager if you have any questions regarding the acceptance or denial of your requested amendment to the protected health information.

Provider signature _____ Date _____

Form 7.80