Shoulder and Hand Therapy Center

Ron French, OT, CHT
849 Volunteer Dr. STE 8
Paris TN 38242

Medical Record Amendment Request

Patient Name: _____ Date: _____

Patient Address: _____

City: _____ St: _____ Zip code: _____

Date of birth: _____ Phone number: _____

Date(s) of disputed entry(ies): _____

_____

1) Describe how the disputed documentation is incorrect and/or incomplete.

2) Write exactly what you think the documentation should state be accurate and/or complete. If additional space is needed, use a separate sheet of paper and attach to this form. **Do not write of back of this form.**

_____

_____

_____

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_____

If your request is accepted, a coy of the amended information will be sent to any persons who previously received this information. If you would like a copy, or there is anyone else you would like the amended information sent to, please provide the name(s) and addresses below:

Name: _____ Address: _____

Name: _____ Address: _____

Signature below is acknowledgement I have read and understood the amendment request instructions and procedures that follow once I submit this request.

Signature: _____ Date: _____
Patient, Parent, Guardian, or Personal Representative

Print name: _____Relationship: _____

FOR OFFICE USE ONLY: ID verification: ☐ Driver's License ☐ Gov. ID ☐ Other: _____

Request verified and processed by: _____ Date: _____

Request has been: ☐ Granted ☐ Partially granted ☐ Denied

Patient Instructions for Requesting Amendment to Their Medical Record

1. You have the right to request an amendment to your medica record if you believe the information is incorrect or incomplete.

2. To request an amendment to your medical information, fill out the Amendment Request form entirely, and sign.

3. You will be notified of the acceptance or denial of your request within 60 days of its receipt. If there is a delay, you will be notified in writing on a one-time 30 day extension. The notification will include a reason for the delay and the date by which the action will be completed.

4. If your request has been accepted and you have authorized the provider to disclose any amended information, we will send copies of any amended or corrected information to the parties who previously received records and the one(s) you have indicated on the request form.

5. If your request has been denied, you have the right to submit a written statement of disagreement to us.

6. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, http://www.hhs.gov/ocr/privacy/index.html

7. The Amendment Request and any additional documents related to the request will become part of your permanent medical record and may be disclosed to future requestors as it relates to the subject of the amendment.

8. Call our office if you have additional questions or concerns.

9. Once the form is completed, you may mail, fax, or deliver in person to:

   Address:
   Ron French, OT, CHT
   Shoulder & Hand Therapy Center
   849 Volunteer Dr. STE 8
   Paris, TN 38242

   Phone: (731) 642-0778
   Fax: (731) 642-6488