Request for Correction/Amendment of Health Request for Information
Children's Orthopaedic & Scoliosis Surgery Associates, LLP

You have the right to request an amendment to your protected health information. If you would like to request an amendment to your protected health information, please complete the form below and hand it to the Privacy Officer.

Patient Name :_____ Birth date: _____

Patient Address: _____
_____
_____

Date of amendment request: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be 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(s) or individual(s).

Name/Address: Name/Address:

_____ _____

_____ _____

_____ _____

_____ _____

Name/Address: Name/Address:

_____ _____

_____ _____

_____ _____

_____ _____

Note: If you have additional names, please attach an additional sheet to this page.

I understand that by listing the name(s) and address(es) of other organizations on this Amendment form, I am asking to disclose the requested amendment to these organizations. I therefore give specific permission to Children's Orthopaedic and Scoliosis Surgery Associates (COSSA), LLP to disclose the amendment to these organizations, and I understand that COSSA will take reasonable steps to send the requested amendment to these organizations.

In addition, I understand Children's Orthopaedic and Scoliosis Surgery Associates, LLP may be required to send this amendment to Business Associates or other organizations that Children's Orthopaedic and Scoliosis Surgery Associates, LLP identifies as needing the amendment. I therefore give specific permission to Children's Orthopaedic and Scoliosis Surgery Associates, LLP to send the requested amendment to these organizations identified by Children's Orthopaedic and Scoliosis Surgery Associates, LLP as needing the amendment.

I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be no longer available to act on this amendment request, and present to Children's Orthopaedic and Scoliosis Surgery Associates, LLP evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, Children's Orthopaedic and Scoliosis Surgery Associates, LLP may deny the amendment request.

By signing below, I fully acknowledge and agree to the above terms.

_____

Signature of Patient

_____

Date

Children's Orthopaedic & Scoliosis Surgery Associates, LLP

FOR OFFICE USE ONLY

Name of Patient: _____Date of Birth: _____

Date Amendment Received: _____

Amendment Reviewed by: _____

Amendment has been: [ ] Accepted [ ] Accepted in part [ ] Denied

If denied or accepted in part, check reason(s) for denial:

[ ] PHI was not created by this organization
[ ] PHI is not part of patient's designated record set
[ ] The patient's record is accurate to the standard of reasonable accuracy as defined by Section 164.516 of the federal regulations.
[ ] Other: _____
_____
_____

Comments of Healthcare Practitioner or Reviewer:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Reviewer Date

Has patient asked for a review of the decision?
[ ] Yes, letter asking for review received on _____.

Decision reviewed on _____ by _____.

Reviewing official's decision:
[ ] Affirm decision [ ] Overturn decision (complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on _____.

_____
Reviewing Official's Signature

_____
Date