Patient's Name:_____
Last First MI Previous Name if Any

DOB:_____ Date of Service: _____

Telephone:_____ _____
Home Work

Address:_____
Street City State Zip

Explanation of information to be amended, including whether amendment applies to all records or one record in particular:_____

Explanation of why information should be amended:_____

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices and understand that although I may request that records be amended, Provider does not have to agree to amend them. By accepting this Request, Provider is agreeing only that it will review the request and determine whether or not it will amend the records. I understand that Provider has 60 days in which to act on this request and may request a 30 day extension provided I am notified of the extension within the original 60 day timeframe. In the event Provider denies this request, I understand that I will be informed in writing of the reason for the denial and the opportunity to appeal the Provider's decision.

_____ _____
Signature of Patient/Guardian/Representative Date Signed

_____
If Guardian/Representative-State Relationship to Patient

FOR INTERNAL USE ONLY

Name of Authorized Individual:_____ Position:_____

Initial whichever is applicable:

- Having read the above request, the request is hereby granted:_____
- Having read the above request, the request is hereby denied:_____

_____ _____
Signature of Authorized Individual Date Signed

Pt Name:
Acct# MR#

Adm: DOB:
Summit Healthcare Regional Medical Center

Summit Healthcare
2200 E Show Low Lake Rd • Show Low, AZ 85901

525 (05/20)

REQUEST FOR AMENDMENT OF INFORMATION

AMEND