HEALTH INFORMATION CORRECTON and/or AMENDMENT REQUEST FORM

Patient's Name: _____

Patient's Address:

_____

_____

_____

Patient's Account Number:

_____

You have the right to request that we amend your health information if it is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for us. We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Date of health information entry to be corrected: _____

Explain how the health information entered on your record is incorrect or incomplete. Include what the information should say to be more accurate or complete:

_____

_____

_____

Would you like this amendment forwarded to anyone to whom we may have disclosed your information in the past? If so, please list their names and addresses:

Name	**Address**

_____ _____

Signature of Patient Date

_____

Name of Personal Representative (if appropriate)

_____

Signature of Personal Representative (if appropriate)

Please return this form to this address, or call this number with questions:

Vital Tears HIPAA Privacy Officer
QA@vitaltears.org
10560 N. Ambassador Dr. Suite 210
Kansas City, MO 64153
(816) 255-1300 Ext.502

For Vital Tears Use Only:

Date Received: _____ _____ Accepted _____ Denied

If denied, check reason for denial:

_____ Health information is accurate and complete
_____ Health information was not created by (Practice Name)
_____ Health information is not part of patient's designated record set
_____ Health information is not available for patient inspection as required by federal law (e.g., psychotherapy notes)

Date and method of informing individual of decision: _____

If denied, did patient submit a Statement of Disagreement? _____ YES _____ NO

If denied, did patient request a disclosure of the Request and Denial with future disclosures? _____ YES _____ NO

Comments:_____