HIPAA – FORM C
PEDIATRIC ASSOCIATES
REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name:_____   Date of Birth:_____

Patient Address:_____   Chart / Account #: _____
        Street

_____
        City, State, Zip

_____
        Phone

Type of Entry to be Amended_____:_____

☐ *Visit note*
☐ *MA note*
☐ *Hospital note*
☐ *Prescription information*
☐ *Patient history*

Please explain how the entry is inaccurate or incomplete.

_____

_____

Please specify what the entry should say to be more accurate or complete.

_____

_____

_____   _____
Signature of Patient or Legal Guardian   Date

FOR INTERNAL PURPOSES ONLY:
Date Request Received: _____
Date Compliance Officer Received this Request: _____
Compliance Officer Signature: _____

Amendment has been: ☐ Accepted

                             ☐ Denied

                             ☐ Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

☐ PHI was not created by this organization.

☐ PHI is not available to the patient for inspection in accordance with the law.

☐ PHI is not a part of patient's designated record set.

☐ PHI is accurate and complete.

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Comments from healthcare provider who provided service:

_____

_____

_____

Name of Staff Member Completing Form: _____

Title: _____

_____
Signature of Healthcare Provider Who Provided Service   Date

*If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, *Attn: Chester Slonaker, MD, CHCO, Compliance Department, Pediatric Associates, 900 S. Pine Island Road, Suite 900, Plantation, FL 33324.* If you do not provide us with a statement of disagreement, you may request that we provide your original request for amendment and our denial with any future disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Compliance Officer, Chester Slonaker, MD, CHCO at the above stated address or the Secretary of the U.S. Department of Health & Human Services.

*Practice must inform patient that a written request is required, and that the patient is required to provide a reason to support the requested change.