APPENDIX A

PATIENT REQUEST FOR AMENDMENT OF RECORDS

病人要求修改記錄

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in out records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information and the process we follow once we have received your request. To request an amendment to your records, complete and return the following request form.

您有權要求我們修改記錄中可能用於就您和您的治療做出決定的大部分信息，只要我們在記錄中保留這些信息。

請參閱我們的隱私慣例通知，以更詳細地說明您要求修改此信息的權利以及我們在收到您的請求後遵循的流程。

要請求修改您的記錄，請填寫並退回以下請求表.

PATIENT INFORMATION

病人信息

Patient's Last Name: 病人的姓氏:_____	First: 病人的名字:_____	MI: 中間名首字母: _____
Address: 地址: _____ _____ _____	Telephone: 電話:	
	Daytime: 白天: _____	
	Evening: 晚上: _____	
	Email (optional): 電子郵件（可選）: _____	

AMENDMENT REQUEST

請求修改

Please answer the following questions. You may attach a separate page if more space is needed.

請回答以下問題。如果需要更多空間，您可以附上單獨的書頁。

What information would you like to amend?

您要修改哪些信息？

_____

_____

How do you believe the information should be amended?

您認為應該如何修改信息？

_____

_____

_____

Why do you believe the information should be amended? Please attach any supporting documentation, if needed. Your request may be denied if you do not provide a reason to support your request.

為什麼您認為應該修改信息？如果需要，請附上任何支持文件。如果您沒有提供支持您的請求的理由，您的請求可能會被拒絕。

_____

_____

_____

_____

Is this request being made because of an emergency or other urgent situation? If so, please describe the nature of the emergency or urgency below and the date you need the information amended. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable request.

提出此請求是因為緊急情況還是其他緊急情況？如果是這樣，請在下面描述緊急情況或緊急情況的性質以及您需要修改信息的日期。我們不能保證我們會在您的截止日期前完成，但我們會盡力滿足合理的要求。

PATIENT UNDERSTANDING AND SIGNATURE

病人理解和簽名

By signing below, I am requesting that Maimonides Medical Center amend my health information as I have explained above.

通過在下面簽名，我請求 *Maimonides Medical Center* (邁蒙尼德醫療中心) 修改我的健康信息，正如我上面所解釋的。

_____ Signature of Patient or Personal Representative 病人或個人代表的簽名	SEND COMPLETED FORM TO: 將完成的表格發送至
_____ Print Name of Patient or Personal Representative 病人或個人代表的正楷姓名	Maimonides Medical Center 4802 Tenth Avenue Brooklyn, New York 11219 Attn: HIS Department
_____ Date 日期	
_____ Description of Personal Representative's Authority 個人代表的權限說明	

For Maimonides Medical Center Use Only:

Date Received: (MM/DD/YY) _____/_____/_____

Disposition of Request: _____ GRANTED _____ DENIED _____ PARTIALLY DENIED

Patient Notified In Writing on This Date: (MM/DD/YY) _____/_____/_____

Name of HIS Department Staff Member Processing This Request: