APPENDIX A

PATIENT REQUEST FOR AMENDMENT OF RECORDS

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.

PATIENT INFORMATION

Patient Name: _____
Last First MI

Address:
_____
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address (optional):
_____

AMENDMENT REQUEST

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

What information would you like to amend?

_____
_____
_____
_____

How do you believe the information should be amended?

_____
_____
_____
_____

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.

_____
_____
_____
_____

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.

_____

_____

_____

_____

PATIENT UNDERSTANDING AND SIGNATURE

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

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

Maimonides Medical Center
4802 Tenth Avenue
Brooklyn, New York 11219
Attn: HIS Department

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: