## PATIENT AMENDMENT REQUEST FORM

As a patient you have the right to request amendments to your protected health information.
Protected health information includes medical records, physician's notes, images, laboratory results, etc.

**Today's Date:**
**Patient Name:** **Birth Date:**
**Patient Address:**

Description of information to be amended: (e.g. medical record, lab results)

Date(s) of the information to be amended: (date of office visit, date of session, date of other services)

What is the reason for requesting amendments? (e.g. outdated, incomplete, or incorrect)

What are the requested amendments?

Do you know of anyone who may have received or relied on the information in question?
(e.g. doctor, health plan, or other health care provider) Yes _____ No _____
If yes, who?

Signature of patient or legal representative:_____ Date_____

**FOR INTERNAL USE ONLY**

Amendment has been: Accepted _____ Denied _____
If denied, the reason for denial
☐PHI was not created by the organization
☐PHI is part of the patient's designated record set
☐Federal law forbids making the PHI in question available to the patient for inspection
☐PHI is accurate and complete

Comments:

**First Choice Counseling Center**
**600 Reisterstown Rd Suite 400 Pikesville, MD 21208**
**410 929 4793(Office)**
**410 779 900 (Fax)**
**Email: Fccc1@hushmail.com**

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|---|---|
| Signature of staff person: | Date: |
| Print Name and Title: | |

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