REQUEST TO AMEND PHI

Name of Patient (Type or Print) **FMOA Medical Record #**

The following summarizes our policies and procedures with respect to amending Protected Health Information (PHI):

- **Requests to amend information must be submitted in writing. The attached page is provided for your convenience. Use as many copies of this page as needed.**

- **Your request will be reviewed by FMOA's Compliance/Privacy Officer and your Primary Care Physician (PCP).**

- **If FMOA determines that the amendment you have requested should be made, the records will be updated as required by federal regulations.**

- **If FMOA determines that the information in our records is complete and accurate, your request will be denied and the records will not be amended.**
  - ✓ **A written notice of this decision will be sent to you as required by federal regulations.**
  - ✓ **You will have an opportunity to send us a written statement explaining your disagreement with this decision.**
  - ✓ **That statement will be forwarded to FMOA's HIPAA Compliance Committee. Your statement will be included in your records, along with any response that the Committee believes is necessary to help future users of the information understand that information.** ***(You will be given a copy of any response that we include in the record.)***

The following _____ page(s) describe the amendment(s) I am hereby requesting to my PHI.

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative to Patient

If you need help with this form, please contact either FMOA's Front Office Manager or the Compliance/Privacy Officer at **(434) 973-9744**.

INFORMATION TO BE AMENDED *(Use as many copies of this page as needed.)*

Item To Be Changed: _____

_____

Data Source: *(e.g. medical record, billing documents)* _____

How You Would Like It Changed? _____

_____

Reason For Change? _____

_____

[NOTE: If no reason is given, your request will be denied.]

FMOA Response *(to be completed by FMOA)***:** _____

_____

_____

_____ _____

Signature of Compliance/Privacy Officer or MD **Date**

Item To Be Changed: _____

_____

Data Source: *(e.g. medical record, billing documents)* _____

How You Would Like It Changed? _____

_____

Reason For Change? _____

_____

[NOTE: If no reason is given, your request will be denied.]

FMOA Response *(to be completed by FMOA)***:** _____

_____

_____

_____ _____

Signature of Compliance/Privacy Officer or MD **Date**