Amendment Request

MRN:_____

Patient Name:_____ Today's Date:_____
Patient Address:_____
City:_____ State: _____ Zip:_____
Last Four Digits of SSN:_____Date of Birth:_____Phone:_____
Clinic Site:_____ Provider:_____

Please complete one form for each amendment request.
Date of disputed entry:_____
In what documentation did you see this disputed entry: _____
(1.) Describe how the disputed documentation is incorrect and/or incomplete. (2) Write exactly what you think the documentation should state to be accurate and/or complete. If additional space is needed, use a separate sheet of paper and attach to this form. DO NOT write on the back of this form.

_____
_____
_____
_____
_____
_____
_____

If your request is accepted, a copy of the amended information will be sent to any persons who previously received this information. If there is anyone else you would like the amended information sent to, please provide the name of the organization/ individual and address below:

Name:_____ Address: _____

Name:_____ Address: _____

Signature below is acknowledgement I have read and understood the amendment request instructions and procedures that follow once I submit this request.

Patient or Legal Representative's Signature:_____

Patient or Legal Representative's Printed Name:_____

Relationship to Patient:_____Date:_____

For Office Use: Request verified and processed by:_____Date:_____
Provider Reviewed on:_____Provider Signature:_____
Request has been: ☐Granted ☐Partially Granted ☐Denied
Form of ID presented for verification: ☐Driver's License ☐Government ID ☐Other (specify)

Amendment Request

MRN:_____

Patient instructions for requesting an amendment to your medical record.

1. You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete.

2. To request an amendment to your medical information, fill out the Amendment Request Form entirely.

3. You will be notified of the acceptance or denial of your request within 60 days of its receipt. If there is a delay, you will be notified in writing on a one-time 30 day extension. The notification will include a reason for the delay and the date by which the action will be completed.

4. If your request has been accepted and you have authorized ACP to disclose any amended information, we will send copies of any amended or corrected information to the parties who previously received records and the one(s) you have indicated on the request form.

5. If your request has been denied, you have the right to submit a written statement of disagreement to the Corporate Compliance Director at ACP.

6. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. http://www.hhs.gov/ocr/privacy/index.html

7. The Amendment Request and any additional documents related to the request will become a part of your permanent medical record and may be disclosed to future requestors as it relates to the subject of the amendment.

8. Contact ACP's Corporate Compliance Director at (520) 327-0460 Ext. 1110 for additional questions or concerns.

9. Once the form is completed, you may mail, fax, or deliver in person to your provider's clinical site or to the attention of Arizona Community Physicians, Attn: Corporate Compliance Director, 5055 E. Broadway Blvd., Tucson, AZ 85711. Fax #: (520) 795-0225.