830 King Avenue
Athens, Georgia 30606
1550 Timothy Road Suite 104
Athens, Georgia 30606
(706) 425-2400 Phone
(706) 425-2410 Fax

1550 Timothy Road Suite 103
Athens, Georgia 30606
(706) 850-5667
(706) 850-6249 Fax

REQUEST FOR CORRECTION/AMENDMENT OF PHI

You have the right to request Athens Spine Center to make amendments to the protected health information (PHI) that Athens Spine Center retains on your behalf if you believe information was documented in error or needs to be amended. Each request will be carefully reviewed, and amendments made if warranted. You will be notified when your request has been approved or denied.

Name: ____ DOB: ____________________

Address: ____

Phone: ____________________ Last 4 of SSN: ________________ MRN: ________________

Date of Entry to Be Corrected/Amended: ____

Information to Be Corrected/Amended: Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate and complete? Use additional sheets if needed and attach to this form.

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Athens Spine Center will make a reasonable effort to provide the amendment to other persons who Athens Spine Center knows to have received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.

☐ I agree to allow Athens Spine Center to release any amended information to individuals or entities as described above.

☐ I do not agree

If you are aware of any other person(s)/entities that may have a copy of the medical record you seek to have amended, please list the name(s) and address(es) below:

____

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I hereby authorize Athens Spine Center to notify the persons/entities listed above that may have a copy of the record I seek to have amended and to provide them with the amended information. I understand that an amendment will be made within 60 days of the receipt of this request. I understand Athens Spine Center may extend the time frame for an additional 30 days for which I will be provided with a written statement for the reason(s) for the delay and the date by which I can expect the request to be fulfilled.

Signed by: ____ **Date signed:** ________________

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative: ____________________________________

[If Signed by a Personal Representative, please state such person's authority to act for the Individual]

FOR ASC USE ONLY	
DATE RECEIVED:	AMENDMENT HAS BEEN: ☐ Approved ☐ Denied
REASON FOR DENIAL:	
SIGNATURE/TITLE OF ASC EMPLOYEE PROCESSING:	DATE: