Radiology Ltd.

Request to Amend/Correct Protected Health Information

Patient's Legal Name: ____

Address:____DOB:________________

City:______________________________State:______________Zip Code: ______________

Telephone number: ____________________________

Please explain in detail what the information in the record should say to be more accurate or complete. For example, "The report dated October 1, 2020, listed an incorrect date of birth. My date of birth is January 1, 1965."

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We will review your request and respond within 60 days of receiving your request. A copy of your request will be added to your medical record only if USRS rejects your request. If the request is approved, we will send the changes to you and to anyone you identify for us to send the amended record to. Please note, we are not required to amend your record if:

- *The existing health information is accurate and complete.*
- *This request does not pertain to the patient's medical or financial records.*
- *The involved health information was not created by USRS.*
- *The involved information is not available for inspection under federal or state law.*
- *The record no longer exists or cannot be found.*

If this request is denied, in whole or in part, we will notify you of the reason and provide you with the opportunity to include a statement of disagreement in your record.

If your request is amended, where would you like copies of the amendment to be sent? Please provide name and contact information.

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____ ____________________

Signature of Patient/Personal Representative* Date

*If a Personal Representative, provide relationship and authority (e.g., parent, legal guardian, Power of Attorney). ____

INTERNAL USE ONLY

Date received:__________Correction/Amendment has been:_Accepted ___Partially Accepted____Denied

Date patient was notified of decision:____________________(Include copy of letter in chart)

If any part of the request is denied, provide reason:

___ accurate and complete	___does not pertain to patient's medical or financial records	___ information was not created by USRS and the originator is still available to make the change
___ information is not available due to federal or state law	___ record no longer exists or cannot be found	other:

Name of reviewing staff member:______________________________Signature:______________________Date: ______________

Reviewing physician:______________________________Signature:______________________Date: ______________

(Physician signature not required for changes involving only demographic information)