Appendix 2.14.2.1

West Michigan Endodontists - Request for Amendment

This form documents a patient's request to amend the patient's protected health information in the practice's designated record set.

To the Patient: Please use this form to ask our dental practice to change any information about you in our records. All requests for changes to our records must be in writing and must state the reason for the change. You must return this form to the Privacy Official listed on this form.

Patient Information
Name of Patient (print name):_____

Patient's Date of Birth:_____ Today's date: _____

Patient Signature:_____ Date:_____

For Personal Representative of the Patient:
Your Name:_____

Your Relationship to Patient:_____

Personal Representative Signature:_____ Date:_____

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative:_____ Date:_____

Requested Amendment
Please describe in detail how you want your records changed:_____

_____

_____

Reason for requested change:_____

_____

_____

Contact Person
Please contact the Privacy Official if you have any questions relating to your request to amend records.

Privacy Official Name:_____ Telephone: _____

Address:_____