

Choices Counseling & Resource Center, P.A.

Request to Amend Health Records

The purpose of this form is to request an amendment in medical records maintained Choices Counseling & Resource Center, P.A. Upon receiving your request, the information will be reviewed and a decision letter will be sent to you or the person designated.

Request to amend information for

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ DOB: _____

Your relationship to client: Self Parent/legal guardian Legal representative
 Other (describe) _____

Please list which information you desire to be amended in the following format.

1. Identify the information (preferably a copy of the information or document)
If no copy is available describe the information in detail (e.g., date of service, type of document)
2. Indicate what is inaccurate or incomplete
3. Describe what amendment(s) should be made

Please list who should receive copies of the amended information

Mail to: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____

Mail to: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____

Mail to: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

I authorize the above-listed amendments to be sent to me and others listed

Client's Signature: _____ Date: ____/____/____

Parent/guardian/legal representative (if applicable)

Signature: _____ Date: ____/____/____

Witness (if client is unable to sign):

Signature _____ Date: ____/____/____