SANJIV GOEL, M.D., F.C.C.P, F.A.C.C.
2100 LYNN ROAD SUITE 205 • THOUSAND OAKS, CALIFORNIA 91360
PHONE (805) 497-3585 FAX (805) 497-1313

Request for Amendment of or Addition to Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. We will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures. Alternatively, you may request that we append to your medical record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

I, _____ (*print name*) believe that the following health information pertaining to me is incorrect or incomplete (please copy below or attach the challenged entry and identify its location in the medical record):

_____

_____

_____

_____

_____

I believe that the information described above is incomplete or incorrect for the following reasons:

_____

_____

_____

_____

_____

Please choose <u>one</u> of the following:

ADDENDUM REQUEST:

☐ I, _____ (*print name*) hereby request that the attached statement of no more than 250 words be made a part of any medical record (*attach statement*). I understand that you will attach this to my record and include it with each future disclosure of the contested portion of my medical record.

AMENDMENT REQUEST:

☐ I, _____ (*print name*) hereby request that you amend the health information identified above as follows:

_____

_____

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Additionally, I request that the following people be notified of the correction:

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

We must tell you within sixty (60) days if we will make the change you requested, or that we need more time (up to 30 more days) to decide. We do not have to make your requested changes if (1) they do not involve your medical records, billing records or other records that we use to make decisions about you; or (2) they involve records you have no right to access; or (3) we did not create the information (unless the person or entity that created the information is unable to act on your request; or (4) the information is already accurate and complete.

If we agree to change your information, we will send the change as you have requested, above.

Optional: Do not send the change to anyone other than those I have specified. _____
Initial

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

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