

Broadway Medical Clinic, LLP

AMEND/APPEND MEDICAL RECORD FORM

Patient Name: _____ Phone Number: () _____ (Day)
() _____ (Evening)

Patient Address: _____
(Street or PO Box)
(City) (State) (Zip)

1. Date of Medical Record Entry to be Amended: _____
2. Medical Record Language to be Amended/Appended: _____

3. Amendment: _____

4. Reason for the Amendment: _____

5. Please help us identify persons who have received the Information (prior to Amending/Appending):
Name Organization/Address Phone Number
_____ () _____
_____ () _____
_____ () _____
_____ () _____
_____ () _____

6. Do you authorize us to provide the information in items no. 3 and no. 4 to the persons/organizations listed in item no. 5?
Yes
No Do not provide the information to: _____

TO OUR PATIENTS: You have the right to submit an Amend/Append Medical Record Sheet to be made a part of your medical record. This right does not permit you to alter or change the original record created by your physician or his/her staff. We may deny your request to amend or append your records.

Amend/Append Medical Record Accepted Amend/Append Medical Record Denied
Reason for Denial _____
This Amend/Append Medical Record Sheet is to Be Made a Part of the Medical Record of:
(Patient Name) (Date)

Signature of Patient _____ Date _____

If we have denied your requested amendment, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).

If we have denied your requested amendment, and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this document with any future disclosures of the information identified in items no. 1 and no. 2 above. Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our "Notice Of Privacy Practices" or our legal obligations under state or federal law, you may contact our Associate Privacy Officer regarding your complaint, and you may file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.