



### Medical Record Amendment/Correction Form

**Client Identification:**

Client Name: _____		Date of Birth: _____		Client ID #: _____	
Client Address: _____					
Street		Apt #	City	State	Zip
Home Phone: (____) _____		Work Phone : (____) _____		Cell Phone : (____) _____	

**Request for Amendment:**

<input type="checkbox"/> Correction <input type="checkbox"/> Addition			
1. Date of Medical Record Entry to be Amended: _____			
2. Medical Record language to be Amended/Corrected: _____			
3. Amendment/Correction: _____			
4. Reason for the Amendment/Correction: _____			
5. Identify persons who have received the information (prior to Amendment/Correction):			
Name	Organization	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
6. Do you authorize us to provide the information in items no. 3 and no. 4 to the persons and organizations listed in Item no. 5?			
<input type="checkbox"/> Yes <input type="checkbox"/> No      Do not provide the information to: _____			
<p><b>TO OUR PATIENTS:</b> You have the right to submit a Medical Record Amendment/Correction Form 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 healthcare provider or his/her staff. We may deny your request to amend or correct your records.</p> <p><i>By your signature below, you acknowledge that you understand and agree to the above information.</i></p>			
_____	_____	_____	_____
Name (Printed)	Signature	Date	
If Personal Representative, please provide proof of identity and/or describe authority: _____			

This section is for agency use only

<input type="checkbox"/> Amendment/Correction <b>ACCEPTED</b>		
<input type="checkbox"/> Amendment/Correction <b>DENIED</b>		
Reason for Denial:	<input type="checkbox"/> Information was not created by this agency <input type="checkbox"/> Information was not part of a designated record set <input type="checkbox"/> Information is accurate and complete <input type="checkbox"/> Information is not available to Client per federal law	
by: _____	_____	_____
Staff Signature	Title	Date

This Amendment/Correction form is to be made a part of the medical record of:

_____	_____	_____
Patient's Name (Printed)	Patient's Signature	Date

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If we have denied your requested amendment/correction, 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/correction 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 #7 and 8 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 Quang (Chris) Tran, L.Ac. the Privacy Officer of Acupuncture Wellness Center at 504-362-8020 regarding your complaint. You may also file a complaint with the 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.

\_\_\_\_\_  
Privacy Officer

\_\_\_\_\_  
Date