Request to Amend Protected Health Information

Patient name *(please print)*: ____________________

Address: ____________________ City: ____________ State: ____________

I request that Cardiovascular Consultants (CVC) amends or corrects protected health information about me (or as the authorized representative, of named patient) that CVC maintains in a designated record set in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended.

Describe specific amendment requested *(please print)*: ____________________

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Reason(s) for requested amendment *(please print)*: ____________________

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By signing this Request to Amend, I understand that:

- o CVC will only amend information that is contained in a designated record set maintained by CVC.
- o If CVC is unable to take action within 60 days, CVC may extend the time for taking action by 30 days by providing me written notice of the reason for delay and the date by which it will complete its action on this request.
- o An accepted amendment does not require CVC to delete any information contained in the designated record set.

This Request to Amend does not constitute CVC's acceptance of the requested amendment.

- o CVC will notify you in writing whether it accepts or denies the requested amendment.
- o CVC may deny the amendment for any of the following reasons:
  - The information is accurate and/or complete;
  - The information is not in the individual's designated record set;
  - The information was not generated by CVC;
  - The information is not subject to inspection under 45 C.F.R. §164.524; or
  - The creator of the PHI to be amended is not available to act on the requested amendment.
- o If the amendment is denied, you may submit a written response if you disagree with the reasons provided.
- o If CVC accepts the amendment, then CVC will contact you to obtain the identification of relevant persons with which you believe the amendment needs to be shared, if any.

I authorize CVC to contact me in writing at the address listed above with information relating to this Request to Amend.

____________________ ____________________

Signature of patient or patient's representative *Date*

____________________ ____________________

Printed name of patient's representative *Relationship to patient*

For CVC Use Only:

Patient Name: ____________________

MRN: ____________________

Location: ____________________

Person(s) responsible for processing:

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