Amendment of Protected Health Information Request Form

I, _____, request that the protected health information in the medical
Print Name

record of _____ whose date of birth is _____
Print Patient Name Month/Day/Year

and mailing address is: _____

be amended as follows: (Print clearly description of changes. Please be as specific as possible about date of note(s), document name, and author of note)

_____

_____

_____

The reason that I am requesting the information be amended is: (Print clearly a reason to support your request, e.g. the information in the record is not accurate or incomplete)

_____

_____

I understand that WESTMED Medical Group is not required to amend information that is accurate and complete, that was not created by WESTMED Medical Group, is not part of the medical information WESTMED Medical Group keeps, or is information I would not be permitted to inspect or copy.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative (Please Print)

If Personal Representative, Description of Personal Representative's Authority

Please return form by using one of the methods listed:

- Mail, addressed to: Health Information Management Department P.O. Box 431 Port Chester, NY 10573
- Phone: (914) 682-6416 Fax: (914) 682-6415
- *Email: medicalrecords@westmedgroup.com

Please note that in accordance with the HIPAA privacy rules, we have 60 days from the date we receive your request to issue a response.

**Disclaimer: Patients should carefully consider the use of email for the communication of protected health information (PHI) and should understand that there are known and unknown risks that PHI may be disclosed to, or intercepted by, unauthorized third parties. These risks include but are not limited to (i) the email being sent to the wrong person due to the sender's use of the wrong email address, (ii) e-mail service provider's ability to archive and inspect communications, and (iii) computer hacking and viruses.*