

**Retina & Vitreous Consultants of Wisconsin
Request for Amendment of Health Information
45 CFR § 164.526**

Please use this form to complete all details of the protected health information (medical record and billing record) that you would like amended. Retina & Vitreous Consultants of Wisconsin will respond to this request within 60 days. If we are unable to respond within that timeframe, we will notify you within the 60 days.

1. Name _____
2. Birth date _____
3. Social Security Number _____
4. Address _____

5. Describe the information you want amended (e.g., lab test results, physician notes)

6. Date(s) of information to be amended (e.g., date of office visit, treatment or other health care services).

7. How is the entry incorrect, incomplete or outdated?

8. What should the entry say to be more accurate or complete?

9. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan or other health care provider)?
☐ Yes ☐ No

If yes, please specify the name(s) and address(s) of the organization(s) or individual(s)

If we accept this amendment, by signing below, you agree that we may provide copies of the amendment to the above-identified organization/individual.

Signature of Patient or Legal Representative: _____

Date: _____

Retina & Vitreous Consultants of Wisconsin Internal Uses Only

Date Received: _____

Assigned to: _____

Date Completed: _____

Response Letter Sent: _____

Amendment Status:

_____ ACCEPTED
Date entered in chart: _____
Changes entered by: _____

If accepted, any other treating providers will be sent amended information.

Other Providers contacted:

Date other providers contacted:

Persons identified by the patient contacted:

Date other persons contacted:

_____ DENIED

Reason for Denial:

_____ Information was not created by this organization.

_____ Information is not part of the patient's medical record.

_____ Federal law forbids making the information in question available to the patient for inspection (see Retina & Vitreous Consultants of Wisconsin *Policy on Access to Health Information*).

_____ Information is accurate and complete.

Privacy Officer Comments:

Signature of Privacy Officer _____ Date _____