Request for Amendment/Correction of Health Information

Date of Request: _____

Patient/Individual

First Name | Middle Initial | Last Name | Date of Birth

Phone Number (with area code) | Email Address (optional)

Requestor (if different from Patient/Individual)

Written permission/documentation must be on file for a party to make a request on the patient's behalf.

First Name | Last Name | Relationship to Patient

Phone Number | Email Address (optional)

Identify the Information You Want Amended/Corrected

Explain the information that needs to be amended and how the information is incorrect/incomplete, including relevant dates. What should the information state to be more accurate or complete? (You may attach any information you have to support your request.)

Review and Sign

This request will be reviewed and may or may not be granted. You will receive a response within 60 days after ASAS receives your request.

- I understand that Colorado Physician Partners is not permitted to alter the original record.
- I understand this request for an amendment will be made part of my permanent record.
- I acknowledge that I have read all of the above information.

Signature of Individual or Individual's Legally Authorized Representative **Date**

X_____ _____

Please send this completed form by mail or email to:

Attn: Privacy Officer
Physician Health Partners
PO Box 13406
Denver, CO 80202-9998

Privacy@Alpine-Physicians.com