TOBACCO FREE CAMPUS

HIPAA – Request for Amendment of Health Information

PATIENT NAME			DATE OF BIRTH
PATIENT STREET ADDRESS			
CITY	STATE	ZIP	TELEPHONE

NOTICE

You may seek to change information in your medical records in order to improve the accuracy or completeness of the information. The original information contained in the record will not be erased or obliterated as a result of this change. Your provider has a period of 60 days from receipt of this request to respond. Once review is complete, the original of this form will be maintained in your medical record and a copy will be provided to you.

MAIL COMPLETED FORM TO

Health Information Management.
743 Spring Street NE
Gainesville, GA 30501

FAX

770-219-2568

Date of record to be changed:

Type of record to be amended: (Ex: visit record–clinical, visit record–administrative, hospital record, prescription data, patient history.)

Please explain how the entry is incorrect or incomplete. What should the entry state in order to be more accurate or complete? If you have a copy of the record, please make proposed changes and attach.

Name and address of who you would like us to notify of the change, ***if it is accepted*** (e.g. personal physician.)

NAME	ADDRESS

PATIENT SIGNATURE OR AUTHORIZED PARTY	RELATIONSHIP TO PATIENT	DATE

FOR INTERNAL USE ONLY | **RECEIPT DATE:**

The Request for Amendment has been ❑ accepted ❑ denied ❑ partly accepted ❑ partly denied

Partial acceptance and denials can be based on the following: the information/record was not created by NGMC, NGPG or THC; the information/record is not a part of NGMC, NGPG or THC medical or billing records; the information/record is not available for inspection in accordance with Georgia law; the information/record is accurate and complete as it exists.

NGMC, NGPG OR THC REPRESENTATIVE:	DATE

If your request has been denied, in whole or in part, you have the following rights:

- to submit a written statement of why you disagree with the denial and send it to the address listed above
- to request that your doctor show this Request for Amendment and the denial with any future disclosures of the information requested in this Request for Amendment
- file a written complaint with the Department of Health and Human Services at:
  Region 4 Health Administrator, 61 Forsyth Street, SW, Suite 5B95, Atlanta, GA 30303

Northeast Georgia Health System is not a provider of patient care services; rather, it is a parent organization of a family of affiliate care providers providing health information management services through its Health Information Department.

Northeast Georgia Medical Center

Northeast Georgia PHYSICIANS GROUP

The Heart Center of Northeast Georgia Medical Center

517-02228

HIPAA - REQUEST FOR AMENDMENT OF HEALTH INFORMATION

FORM # 517-02228 (3/6/2020)

PATIENT IDENTIFICATION: