TGS ENDODONTICS

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The Medical Quarters
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404-256-4772 Phone

PATIENT'S REQUEST TO AMEND PATIENT'S HEALTH INFORMATION

To the Patient: Please use this form to ask us to change any information about you in our records. All requests for changes to our records must be in writing and must state the reason for the change. You must return this form to our Privacy Official listed on the bottom of the form

Patient Information:

Name of Patient (print name): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

For Personal Representative of the Patient:

Your Name: _____

Your Relationship to Patient: _____

Personal Representative Signature: _____ Date: _____

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____ Date: _____

If signing as Patient's Personal Representative, you will need to provide us with a copy of document(s) which give you that legal authority.

Requested Amendment

Please describe in detail how you want your records changed: _____

_____

_____

Reason for requested change: _____

_____

Contact Person

If you have any questions relating to your request to amend your records, please contact our Privacy Official, Marge D. Shapiro, at **404-256-4772** or **by email -** margedshap@hipaa-compliant-forms.com**.**

Print Form

(TGS Rev. 2/7/2014)