Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Request to Amend Patient Records

Please use this form to request the treating physician to amend or make corrections to your medical record. If mailing this form, address the letter to the Compliance Officer listed at the bottom of form.

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street City, State, Zip

I request that the following medical record information be amended (attach a separate document if needed):

_____
_____
_____
_____

Reason for the requested change:

_____
_____
_____

I understand that the clinic will review my request to amend records and provide a written determination within 60 days. I also understand that Federal Regulations may not allow information to be amended under certain circumstances specified by HIPPA Privacy Rules 45 CFR 164.526. If the request is denied, I understand that I may submit a written statement explaining my disagreement with the decision, which statement will be included in my medical records, along with any response from the practice.

If the amendment is approved, in whole or in part, I understand the practice will make the appropriate amendment to my records and also is required to make reasonable efforts to inform and provide the amendment within a reasonable time to other entities or practices who received the PHI.

_____ _____

Patient Signature or Legally Authorized Representative with Title Date

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

Gordon D. Elder, DC
Compliance Officer
Email: drelder@blairclinic.com

