

PATIENT REQUEST FOR AMENDMENT OF RECORDS

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information and the process we follow once we have received your request. To request an amendment to your records, complete and return the following request form.

Patient Name:			
	Last	First	MI
Address:			
Telephone:		(daytime)	(evening)
Email Address	(optional):		
Please answer th	ie following question	s. You may attach a separate page if more space is	needed.
What information	ı would you like to an	nend?	
How do you belie	eve the information sh	ould be amended?	
Why do you belies support your requ		ould be amended? Your request may be denied if you	ı do not provide a reason to
emergency or urg	ency below and the da	n emergency or other urgent situation? If so, please date you need the information amended. We cannot guo accommodate reasonable requests.	
By signing below	, I am requesting Mal	ta Med Emergent Care amend by health information a	s I have explained above.
Signature of Patie	ent or Personal Repres	rentative Da	ıte

6 Medical Park Drive Malta, NY 12020