Central Carolina Surgery, P. A.
1002 N. Church St., Suite 302
Greensboro, NC 27401
336 387-8100

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

This form is used by patients who wish to request an opportunity that information kept in the records of Central Carolina Surgery, P. A. be amended. The following summarizes our policies and procedures with respect to amending patient information:

Requests to amend information must be submitted in writing.

Your request will be reviewed by the Executive Committee and Administrator of Central Carolina Surgery, P. A. and other staff members as appropriate.

If the Executive Committee and Administrator of Central Carolina Surgery, P. A. determines that the amendment you have requested should be made, the records will be updated as required by federal regulations.

If the Executive Committee & Administrator of Central Carolina Surgery, P. A., determines that the information in our records is complete and accurate, your request will be denied. A written notice of this decision will be sent to you as required by federal regulations. You will have an opportunity to send us a written statement explaining your disagreement with this decision. That statement will be included in your records, along with any response that we believe is necessary to help future users of the information understand that information. You will be given a copy of any response that we include in the record.

Information to be Amended
Please identify the information that you believe needs to be amended in the space provided below. Identify the source of the information (i.e. medical records or billing records), the specific information that you believe to be incorrect and the reason you believe the information to be incorrect. If no reason is given, your request will be denied. If you need help with this form, please contact The Administrator of Central Carolina Surgery, P. A. at 336 387-8100.

Item to be changed _____

Data source _____

Change _____

Reason _____

Response _____
(FOR OFFICE USE ONLY – DO NOT COMPLETE THIS LINE)

_____SS#_____
Patient Name (print)

_____
Signature of Patient Date

_____
Signature of Patient Representative Relationship