Concentra

Request Amendment to Health Information in Designated Record Sets

Patient Name:____

Last First MI Maiden or Other Name

Date of Birth:____-_____-_____ Medical Record #:_______________ Phone: ______________________

Address:__________________________________City:______________________ST: ____Zip:_________

Entry to be amended: Date:___________________ Type: _______________________________________

Explain how the entry is incorrect or incomplete and what it should say to be corrected?

____

____

Would you like this amendment sent to anyone we may have disclosed the information to in the past?
If so, specify:

NAME:____

ADDRESS:____ CITY:____________________STATE:____ZIP:____________

I understand that that my request will be processed within the time frames set forth by state law or within 60 days, whichever is less.

___________________________ __________ OR ______________________________________ ____________

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

____

RELATIONSHIP TO PATIENT

You may submit this form:

- In person: to the nearest Concentra medical center
- By mail: Concentra Privacy Office
  P O Box 1438
  Louisville, KY 40202-1438
- By fax: 502.508.3700
- By email: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY

Complete the sections below and email this request to PrivacyOffice@Concentra.com or fax to 502.508.3700 with all records referenced in the request

Date Request Received: ______________❑ mail ❑ in person ❑ email ❑ fax Date sent to Privacy Office: ____________

Amendment Request has been: ❑ Accepted ❑ Denied

If denied, reason for denial is:

❑ Information was not created by this organization
❑ Information is not a part of patient's designated record set
❑ Information is not available to the patient for access as required by federal law
❑ Information is complete and accurate

Comments: ____

_________________________________ ____________________________ ______________ ______________________

Signature of Author of Record Title Date Phone

_________________________________ ____________________________ ______________ ______________________

Signature of Staff Member Title Date Phone

_________________________________ ______________________________

Center Name Location Number

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Concentra®

Solicitud de Enmienda de Información de la Salud en Grupos de Registros Designados

Paciente
Nombre:____
Apellido Nombre Inicial Seg. Nombre Apellido de soltera u otro nombre

Fecha de Nacimiento:____-_____-_____ Archivo Médico #:_______________ Tel:____________________

Dirección:_________________________ Ciudad:________________Estado: _____Cód. Postal:__________

Explique en qué forma la anotación es incorrecta o incompleta y lo que debería decir o corregirse.

____

____

Le gustaría que esta enmienda se le enviara a alguien a quien nosotros le hubiésemos revelado la información en el pasado? Si esto es así, especifique:

NOMBRE:____

DIRECCION:____ CIUDAD:____________________ESTADO:____COD. POSTAL:__________

Yo entiendo que mi solicitud será procesada dentro de los periodos de tiempo establecidos por la ley estatal o dentro de 60 días, cualquiera que sea el menor.

___________________________________ __________ O _______________________________________ _____________
FIRMA DEL PACIENTE FECHA PADRE/ GUARDIAN LEGAL /PERSONA AUTORIZADA FECHA

____
RELACION CON EL PACIENTE

Usted puede enviar este formulario:

- En persona: al centro médico Concentra más cercano
- Por correo: Concentra Privacy Office
  P O Box 1438
  Louisville, KY 40202-1438
- Por fax: 502.508.3700
- Por correo electrónico: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY

Complete the sections below and email this request to PrivacyOffice@Concentra.com or fax to 502.508.3700 with all records referenced in the request

Date Request Received: ______________❑ mail ❑ in person ❑ email ❑ fax Date sent to Privacy Office: ____________

Amendment Request has been: ❑ Accepted ❑ Denied

If denied, reason for denial is:
- ❑ Information was not created by this organization
- ❑ Information is not a part of patient's designated record set
- ❑ Information is not available to the patient for access as required by federal law
- ❑ Information is complete and accurate

Comments: ____

____________________________________ ____________________________ ______________ ______________________
Signature of Author of Record Title Date Phone

____________________________________ ____________________________ ______________ ______________________
Signature of Staff Member Title Date Phone

____________________________________ ______________________________
Center Name Location Number

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