



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: _____

Facility Visited: _____ Approximate date: _____

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 or denial 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.

SIGNATURE OF PATIENT DATE OR 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
5080 Spectrum DR, Ste 1200 West, Addison, TX 75001
ATTN: Privacy Office
- By fax: 214-775-4408
- By email: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY

Complete the sections below and email this request to PrivacyOffice@Concentra.com or fax to 214-775-4408 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