Northwest Las Vegas Location
7455 W. Washington Avenue
Suite 160
Las Vegas, NV 89128

NEVADA ORTHOPEDIC & SPINE CENTER

Henderson Location
1505 Wigwam Parkway
Suite 330
Henderson, NV 89074

Patient Request to Amend Protected Health Information

- You must complete *this* form as a *request* to *amend your protected health information*, created and maintained, by our facility. *Do not* use this form to change your Name, Date of Birth and/or Social Security Number.

- Please *clearly type or print*, as *we will not process incomplete* or *illegible* forms.

Patient Name: _____ Date of Birth _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Best Number(s) for Contact: _____

You have the right to request we amend and/or revise your protected health information within our records. We may deny your request if:

1. we did not create the information.
2. we believe the information is complete and accurate.
3. the information is:
   a. psychotherapy notes.
   b. compiled in anticipation of, or for use in any civil, criminal or administrative action or proceeding.
   c. not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a).

Reason for Request:

_____

_____

_____

Date(s) you believe need to be amended: _____

Being as specific as possible, please describe the requested amendment(s):

_____

_____

_____

Are there any entities, that may have received the document in question, of whom you would like for us to send the amended copy to?

_____

_____

We have 60 days to provide you with our determination for this request.

- If we deny your request, we will provide you with the reasoning in a denial statement. If you disagree, you have the right to file a written statement of disagreement with the denial. You can also request for the amendment, the denial, and your written statement of disagreement be attached to all future disclosures of the PHI.
- If the request is approved, the appropriate changes will be made and a copy will be forwarded to you.

Signature of Patient or Legal Representative: _____

(The *signature* above must be an *original*, *not* a *facsimile* or *copy)*

If signed by someone other than the patient, select authority and provide documentation:

___ Parent ___ Power of Attorney ___ Representative of Deceased's Estate ___ Representative of Incapacitated Adult ___ Other

Printed Name of Signee: _____ **Date**: _____