Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You"℠

Request for Correction/Amendment of Health Information

Patient Name: _____ Birth date: _____

Street Address: _____ City/State/Zip: _____

MR/Account#: _____ Date of amendment request:_____

Entry to be amended:_____

Date & Author of entry: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

_____

_____

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name/Address: Name/Address:

_____ _____

_____ _____

_____ _____

Note: If you have additional names, please attach an additional sheet to this page.

I understand that the SDMI may or may not amend the medical record with an amendment based on my request, and under no circumstances is SDMI permitted to alter the original medical record. In any event, this request for an amendment will be made part of my permanent record.

I understand that by listing the name(s) and address (es) of other organizations on this Amendment form, I am asking ***SDMI*** to disclose the requested amendment to these organizations. I therefore give specific permission to ***SDMI*** to disclose the amendment to these organizations, and I understand that ***SDMI*** will take reasonable steps to send the requested amendment to these organizations. In addition, I understand ***SDMI*** may be required to send this amendment to Business Associates or other organizations that ***SDMI*** identifies as needing the amendment.

I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be no longer available to act on this amendment request, and present to ***SDMI*** evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, ***SDMI*** may deny the amendment request.

By signing below, I fully acknowledge and agree to the above terms.

_____ _____

Signature of Patient Date