HSS

PATIENT REQUEST FOR AMENDMENT OF RECORDS

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information and the process we follow once we have received your request. Note that it may take up to 60 days to complete this request. In the event that we need additional time to complete the request, HSS may extend the time for up to 30 days, in which notice will be provided. To request an amendment to your records, complete the following form and let us know where you would like to receive your response. Please provide a phone number where you would like to be notified should we request any additional information.

PATIENT INFORMATION

Patient Name: _____
Last First MI

Address: _____ _____ _____ _____	Telephone: _____(daytime) _____(evening) Date of Birth _____ Email Address (optional): _____

HSS

AMENDMENT REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

What information would you like to amend?

How do you believe the information should be amended?

Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request.

Is this request being made because of an emergency or other urgent situation? If so, please describe the nature of the emergency or urgency below and the date you need the information amended. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable requests.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Hospital for Special Surgery amend my health information as I have explained above.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

Health Information Management
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
Or
Email to: ROIrequest@hss.edu
Or
Fax to 212-774-7364

For Hospital for Special Surgery Use Only:

Date Received: (MO/DY/YR) ___/___/___

Disposition of Request: ____ GRANTED ____ DENIED ___ PARTIALLY DENIED

Patient Notified In Writing on This Date: (MO/DY/YR) ___/___/___