Orthopaedic Specialty Group, P.C.
305 Black Rock Turnpike, Fairfield, CT 06825

Request for Amendment of or Addition to Protect Health Information

As required by the **Health Insurance Portability and Accountability Act of 1996 (HIPPA)** you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. We will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement setting forth your basis for disagreement with the denial. This statement of disagreement will accompany the information in question for all future disclosures. Alternatively, you may request, in writing, that we provide this request for amendment and our denial of the request with any future disclosures of the information.

I, _____ **(print name)** hereby request that you amend the health information identified below as follows:

I, _____ **(print name)** believe that the following health information pertaining to me is incorrect or incomplete (please attach copy or describe the challenged entry and identify its location in the medical or billing record:

_____
_____
_____
_____
_____
_____

I believe that the information described above is incomplete or incorrect for the following reasons:

_____
_____
_____
_____

Additionally, I request that the following people be notified of the correction:

Name	Address
_____	_____
_____	_____
_____	_____

Orthopaedic Specialty Group, P.C.
305 Black Rock Turnpike, Fairfield, CT 06825

We must notify you within sixty (60) days whether or not will make the change that you requested, or that we need more time (up to 30 more days) to decide. We do not have to make your requested changes if (1) they do not involve your medical records, billing records or other records that we use to make decisions about you; or (2) they involve records you have no right to access; or (3) we did not create the information (unless the person or entity that created the information is unable to act on your request); or (4) the information is already accurate and complete.

If we agree to change your information, we will send the change to the persons (if any) that you requested above. We will also send the change to any other persons that we know received the information before it was amended, unless you instruct us not to.

Optional: Do not send the change to anyone other than those I have specified _____ (Initial)

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by patient, please indicate relationship: _____

NOTE: If you believe that your rights have been violated, you may file a complaint with this medical practice or with the Secretary of the Department of Health & Human Services. All complaints must be submitted in writing to our Privacy Officer at the address listed at the top of this form. You will not be penalized for filing a complaint.