GARNER RHEUMATOLOGY
& INFUSION CENTER

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MEDICAL RECORD AMENDMENT REQUEST FORM

I,_________________________________, request that Garner Rheumatology and Infusion Center, PLLC ("***Practice***") change / amend my medical record because (please explain what is to be changed or amended and why):

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For my medical record to be more complete / accurate, it should say:

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Patient Signature:_________________________________ Date:_______________ DOB:________________

Patient Printed Name:_____________________________

Privacy Officer Action / Comments (Action Must Be Taken Within 60 Days of Request):	
☐ Request Accepted Without Change ☐ Request Denied for the Following Reason(s): ☐ Information is not part of the designated record set. ☐ The information is accurate and complete. ☐ Under HIPAA, patient is restricted from accessing or amending this information.	
☐ Practice requests a 30-day extension to respond due to:	
Signature of Privacy Officer:	Date: