ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

3712 MacArthur Blvd. Ste 208. New Orleans, LA 70114
Tel. 504-362-8020
info@nolaacupuncture.com
www.nolaacupuncture.com

Medical Record Amendment/Correction Form

Client Identification:

Client Name:_____ Date of Birth:_____ Client ID #:_____
Client Address:_____
Street Apt # City State Zip
Home Phone:(_____)_____ Work Phone : (_____)_____ Cell Phone : (_____)_____

Request for Amendment:

❑ Correction ❑ Addition
1. Date of Medical Record Entry to be Amended: _____
2. Medical Record language to be Amended/Corrected: _____
_____
3. Amendment/Correction:_____
_____
4. Reason for the Amendment/Correction:_____
_____
5. Identify persons who have received the information (prior to Amendment/Correction):

Name	Organization	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Do you authorize us to provide the information in items no. 3 and no. 4 to the persons and organizations listed in Item no. 5?
❑ Yes
❑ No Do not provide the information to:_____

TO OUR PATIENTS: You have the right to submit a Medical Record Amendment/Correction Form to be made a part of your medical record. This right does not permit you to alter or change the original record created by your healthcare provider or his/her staff. We may deny your request to amend or correct your records.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____ _____
Name (Printed) Signature Date
If Personal Representative, please provide proof of identity and/or describe authority: _____

This section is for agency use only

❑ Amendment/Correction **ACCEPTED**
❑ Amendment/Correction **DENIED**
Reason for Denial:
❑ Information was not created by this agency
❑ Information was not part of a designated record set
❑ Information is accurate and complete
❑ Information is not available to Client per federal law

by: _____ _____ _____
Staff Signature Title Date

This Amendment/Correction form is to be made a part of the medical record of:

_____ _____ _____
Patient's Name (Printed) Patient's Signature Date

See Reverse Side

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If we have denied your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy.)

If we have denied your requested amendment/correction and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this document with any future disclosures of the information identified in items #7 and 8 above. Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our "Notice of Privacy Practices" or our legal obligations under state or federal law, you may contact Chris Q. Tran, L.Ac. the Privacy Officer of Acupuncture Wellness Center at 504-362-8020 regarding your complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.

Privacy Officer _____ Date _____