VIZIA DIAGNOSTICS

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

PURPOSE OF FORM: To allow providers & patients to request amendments/corrections to their health information in a designated record set created and maintained by Vizia Diagnostics.

Patient Information

Patient Last Name | Patient First Name | DOB

Street Address

City | State | Zip

Records/Information to Amend

Date of Record to be amended: _____

Information to be amended: _____

Please explain how the entry is inaccurate/incomplete: _____

_____

Please specify what the entry should say to be more accurate/complete:

_____

_____

If you are aware of any other person(s)/entity that may have a copy of the medical record you seek to have amended, please list the name(s) and addresses here. _____

I understand that Vizia Diagnostics may or may not agree to my amendment request, in accordance with applicable regulations. If my request is accepted, Vizia Diagnostics will supplement my record, but will not make changes to the original record. Regardless of the decision, my amendment request will become a part of my permanent medical record.

_____ _____

Signature of Patient/Personal Representative | Date

_____

Name of Patient/Personal Representative

Please fax or mail completed form to:
678-822-0954 or Attn: Release of Information Specialist, Vizia Diagnostics, 11390 Old Roswell Rd, Suite 100, Alpharetta, GA 30009

OFFICE USE ONLY

Date received:	Date Pt/PR Notified:	☐ Extension required	Case #:
Reviewers:			
☐ **Accepted** ☐ BAs/other entities notified ☐ Pt requests notified ☐ Record amendment completed	☐ **Denied** ☐ PHI not created by Vizia Dx ☐ PHI not available for inspection by Pt/PR ☐ PHI not part of DRS ☐ PHI accurate and complete ☐ Statement of Disagreement received from Pt/PR, date _____ ☐ Vizia Dx Written Rebuttal sent to Pt/PR, date _____		
Comments:			

_____ _____

Release of Information Specialist Signature | Date