Request for an Amendment to Health Information

As a patient of a health care provider at Stamps Health Services you may amend inaccurate or incomplete health information about you. If you want to amend your health information, you must complete this form and return it to: **Privacy Officer, 740 Ferst Dr Atlanta GA 30322.**

This request applies only to the health care provider that you indicate below. If you would like to amend information maintained by more than one office, you must complete a separate form for each provider. There may be a reasonable fee, based upon our costs, to provide this information.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

GTID#: _____Phone number: _____

Address: _____

Please specify the health care provider office that holds the information to which you are requesting an amendment.

Provider Name: _____

Please describe the information that you want to amend (e.g., my address).

_____

_____

_____

Please provide a reason to support your requested amendment.

_____

_____

_____

Please explain how the information is inaccurate or incomplete.

_____

_____

_____

Please state your amendment in the spaces provided below (you may attach additional information as necessary).

_____

_____

_____

_____ _____

Signature of patient or personal representative Date

FOR INTERNAL USE ONLY

Received by: _____ Date: _____ Time: _____

Disposition:

_____

_____

_____

_____

_____

_____

Notification made:

By: _____ Date: _____ Time: _____

Method: _____