City Medical of Upper East Side, PLLC
Premier Care Medical of West Islip, PLLC
City Practice Group of New York, LLC
Premier Care Management Services, LLC

Patient Request for Amendment/Correction of Protected Heath Information

Name: _____ **Date of Birth:** _____

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip Code:**_____

Date of Request: _____ **Account #:** _____

As provided by the Health Insurance Portability and Accountability Act and federal regulations, patients have the right to request an amendment or correction to their protected health information ("PHI"). Patient requests will be acted upon by CityMD within 60 days of the date the request is received. However, if CityMD is unable to act in the request within such time frame, CityMD will provide a written notice within 60 days explaining the reasons for the delay and the date by when CityMD will act, which shall be within 90 days of the date the request is received. Once your request has been acted upon, your request for amendment will either be granted or denied.

If denied, you will be notified in writing if the reasons for the denial. If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to CityMD. If you do not provide CityMD with a statement of disagreement, you may request that CityMD provide your original request for amendment and CityMD's denial with any future disclosures of PHI that is the subject of the requested amendment. Additionally, you may file a complaint with CityMD's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services. Please refer to CityMD's Notice of Privacy Practices and other policies for a complete statement of your rights.

Please indicate specifically the date(s) of service(s), what information you wish to have amended, what your information should state to be more accurate or complete, and the reason for requesting the amendment. You may attach a separate sheet if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____

FOR OFFICE USE ONLY: Date Request was received: _____
Name of staff member: _____
Request ☐ Accepted ☐ Denied
If denied, specific reason: _____
_____