Gilbert Center
For Family Medicine

652 E. Warner Rd, Suite 107 Gilbert, AZ 85296
Phone: *480-539-8680* **Fax:** *480-539-1763*
WWW.GILBERTCENTER.NET

Request to Amend or Supplement Health Records

Your Right to Request Amendment Under HIPAA Privacy Rule — 45 CFR §164.526

PATIENT INFORMATION

Last Name | First Name | Middle Name / Initial | Date of Birth

Street Address | City | State | Zip | Phone

Email Address | Medical Record # (if known) | Date of Request

RECORD(S) TO BE AMENDED OR SUPPLEMENTED

Please be as specific as possible. Identify the record, note, or entry you believe is incorrect or incomplete. Attach additional sheets if necessary.

Date of Service / Approximate Date of Record

Type of Record (e.g., Progress Note, Lab Result, Discharge Summary)

Treating Provider / Department

Location / Facility Where Record Was Created

Describe the specific information you believe is incorrect, incomplete, or missing:

State what you would like the record to say, or what information you believe should be added:

Attach any supporting documentation? ☐ Yes — describe below ☐ No

YOUR RIGHTS UNDER HIPAA (45 CFR §164.526)

Response Timeline:	We will act on your request within **60 days** of receipt. If we need additional time (up to 30-day extension), we will notify you in writing.
If Approved:	We will amend or supplement the record and notify you, as well as others we know may have relied on the inaccurate information.
If Denied:	We will provide a written denial explaining the reason. You have the right to submit a written Statement of Disagreement that will be included in your record. We may respond to your statement and will include both in any future disclosures.
Grounds for Denial:	We may deny your request if the record: (1) was not created by GCFM; (2) is not part of the designated record set; (3) is accurate and complete; or (4) is not available for your inspection under HIPAA.
Complaints:	If you believe your rights have been violated, contact our Privacy Officer at 652 E. Warner Rd, Suite 107, Gilbert, AZ 85296, or file a complaint with the HHS Office for Civil Rights at 1-877-696-6775 /www.hhs.gov/ocr. We will not retaliate against you for filing a complaint.

Gilbert Center
For Family Medicine

652 E. Warner Rd, Suite 107 Gilbert, AZ 85296
Phone: *480-539-8680* **Fax:** *480-539-1763*
WWW.GILBERTCENTER.NET

PATIENT / AUTHORIZED REPRESENTATIVE SIGNATURE

I certify that the information above is accurate and that I am the patient or the patient's authorized representative. I understand my rights as described above.

Patient Signature _____ Date of Birth _____ Date _____

Legal Representative / Guardian Signature (if applicable) _____ Relationship to Patient / Authority (e.g., POA, Guardian) _____

FOR OFFICE USE ONLY — DO NOT WRITE BELOW THIS LINE

Date Received: _____ Received By: _____

Method: ☐ In-Person ☐ Mail ☐ Fax ☐ Portal

Decision: ☐ Approved ☐ Denied Reason: _____

Action Taken / Notes: _____

Reviewed By (Printed): _____ Signature: _____ Date of Response: _____