Request to Amend Records

ENPOINTE FLEXIBLE SPENDING PLAN – MEDICAL REIMBURSEMENT ACCOUNT

Health Plan/OHCA Name

I hereby request to amend my medical record as follows:

- ☐ Separate document attached.
- ☐ Add the notation below:

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_____

_____

_____

Provide a specific reason for requesting the amendment described above:

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I understand that the office, of which I am requesting this amendment must determine if the amendment is allowed, but under certain conditions specified in the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations hereunder, is not obligated to allow it. I will be notified of their decision within 60 days, as allowed by law.

If the amendment is allowed, it will be maintained as part of my medical record for as long as this office holds the record. I understand that the office may make a written response to my amendment, which will also become part of my medical record, and that I will be notified of any such response in writing within 60 days of its being made.

Covered Person:		
Requested By:	Relationship:	
Signature:	Request Date:	
Address:		
City:	State:	ZIP:

OFFICE USE ONLY		
Reviewed By:	Initials:	Date:
Decision: ☐ Approved ☐ Denied ☐ Response	Decision Notification Sent:	
Response approved by:		Date: