

**SOUND INPATIENT PHYSICIANS, INC.
AMENDMENT APPROVAL**

PATIENT'S NAME: _____

After carefully considering your request to amend the health information for the above patient dated _____, Sound has determined that amendment is appropriate.

We will identify the information in your record(s) that is affected by the change and will insert an amendment to that information or link that information to a description of how that information is amended.

We will also notify the following individuals of the amendment:

- Any individual that you identify as having received the Protected Health Information who needs the amended information.
- Any individual whom we know has the Protected Health Information that is being amended and who has relied, or may rely, on that information to your detriment.

We have identified the following individuals as having received the Protected Health Information that is to be amended and have relied or may rely in the future on that information to your detriment. These individuals will be informed of the amendment that is the subject of your request.

Please list the names and addresses of any other individuals that you believe have received the Protected Health Information that is to be amended and who need to be informed of the amendment.

If you are not the patient, please fill out the following information:

Name: _____

Relationship to Patient: _____

Address: _____

Telephone: _____

SIGNATURE: _____ **DATE:** _____

Please return this form to the following person and address:

James Kodjababian, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422