

**SOUND INPATIENT PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
REQUEST FOR AMENDMENT TO PATIENT INFORMATION**

I hereby request amendment of the health care information maintained on the following patient:

PATIENT NAME: _____

BIRTH DATE: _____ **SSN:** _____

ADDRESS: _____

TELEPHONE: _____

PLEASE DESCRIBE THE HEALTH INFORMATION THAT YOU WOULD LIKE TO HAVE CHANGED OR AMENDED?

PLEASE EXPLAIN WHY THIS CHANGE OR AMENDMENT IS NEEDED?

PLEASE EXPLAIN WHAT YOU WOULD LIKE TO CHANGE OR ADD TO THE RECORD TO MAKE IT MORE ACCURATE OR COMPLETE?

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

Name: _____

Relationship to Patient: _____

Address (if different from above): _____

Telephone (if different from above): _____

Please furnish a copy of any conservator/guardianship papers with this request.

SIGNATURE: _____ **DATE:** _____

All requests for amendment must be submitted in writing to:

Sound Physicians
Attn: Chief Compliance & Privacy Officer
1222 Demonbreun Street, Suite 1601
Nashville, TN 37203
Phone: 1(855) 768 6363
Email: compliance@soundphysicians.com