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: _____ **PHONE:** _____

ADDRESS: _____

EMAIL: _____

PLEASE DESCRIBE THE HEALTH INFORMATION THAT YOU WOULD LIKE TO HAVE CHANGED OR AMENDED. PLEASE INCLUDE DATES OF SERVICE.

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PLEASE EXPLAIN WHY THIS CHANGE OR AMENDMENT IS NEEDED.

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

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I understand that this amendment request will become a part of my medical record. I understand that I will receive a response to my above request within 60 days or I will receive a request for an additional 30-day extension.

Signature of Guardian or Legally Authorized Representative (if patient is a minor or unable to sign)	**Date of Signature**

OR

Signature of Guardian or Legally Authorized Representative (if patient is a minor or unable to sign)	**Date of Signature**	**Description of Authority to Act for the Individual**

Printed Name of Legally Authorized Representative

Authorizations signed by a representative must contain a copy of the guardianship papers or power of attorney.

All requests for amendment must be submitted in writing to:

Chief Compliance & Privacy Officer
Sound Physicians
1222 Demonbreun Street, Suite 1601
Nashville, TN 32703
1(855) 768 6363
Email: compliance@soundphysicians.com