Central Texas Pediatric Orthopedics & Scoliosis Surgery PA

FORM TO REQUEST AMENDMENT OF MEDICAL RECORDS

To our patients: CENTRAL TEXAS PEDIATRIC ORTHOPEDICS & SCOLIOSIS SURGERY PA respects your right to request an amendment or correction to your medical records. Please use this form to make a request to our practice. We will consider all requests made and will respond to all requests.

Patient Information			
Name of Patient			
Name of Physician			
Signature of Patient			
Date Request Made		Patient Date of Birth	
If request is made by Personal Representative of the patient, please complete this section:			
Name of Personal Representative			
Relationship to Patient			
Your Driver's License Number and State			
I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.			
Signature of Personal Representative			
Date Request Made			
Requested Amendment			
Please describe in detail how you want your records amended. Please include the encounter date you are referring to. (continue on back if needed)			
Reason for the Requested Amendment.			
Contact Person – *this is the person we will correspond with concerning the amendment request*			
Name			
Address			
Phone Number			
Please contact CENTRAL TEXAS PEDIATRIC ORTHOPEDICS & SCOLIOSIS SURGERY PA's Privacy Officer if you have any questions relating to your request to amend records.			
Signature			
Patient or Personal Representative			
Date			
For Use by Practice Only: Date Received at Practice		***Hand deliver to Treating Physician***	