

ACUITY EYE GROUP 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's Name: _____

Address: _____

Birth Date: _____ SSN: _____

Telephone: _____

PLEASE DESCRIBE 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: _____

Address (if different from above): _____

Telephone (if different from above): _____

Relationship to Patient: _____

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

SIGNATURE: _____ DATE: _____

All complaints must be submitted in writing to:

Privacy Officer
Acuity Eye Group
200 E. Delmar Blvd., Suite 118
Pasadena, CA 91105

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Privacy Officer

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Pasadena, CA 91105