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: _____

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
100 E California Blvd
Pasadena, CA 91105