Orthopedic Associates
of Dutchess County

1910 South Rd
Poughkeepsie, NY 12601
845-454-0120

6511 Springbrook Ave
Rhinebeck, NY 12572
845-876-7707

918 Ulster Ave
Kingston, NY 12401
845-339-8900

1955 Route 52
Hopewell, NY 12533
845-897-4660

3141 Route 9 W
New Windsor, NY 12553
845-534-5768

OrthoExpress
Walk-In Center
1910 South Road
Poughkeepsie, NY 12601
845-790-HELP (4357)

www.orthoadc.com

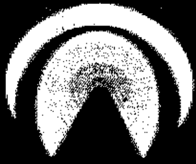
Enclosed please find the Request to Amend Protected Health Information form. According to New York State law a patient requesting an amendment to their medical record must do so in writing.

Upon receipt of the completed form the request will be reviewed by the Practice's Privacy Office (or his/her designee). Response to the request will be processed within 60 days.

Please return this completed request to the attention of Manager of Health Information. If you have any questions please contact us at (845) 454-0120 extension #1241.

Sincerely,

Health Information Management
Orthopedic Associates Of Dutchess County, PC



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REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Please complete the following information:

1. Date: ____________________ Account # ____________________

2. Patient Full Legal Name: ____

3. Date of Birth: ____________________ 4. Social Security Number: __________________

5. Home Address: ____

City: _________________________ State: ______________ Zip: ___________

6. Please describe the health information that you want to correct or change (for example, test results or statements on physical exam form). ____

____

7. What date(s) of the information you would like to correct or change? As accurately as possible, please list the dates(s) of the office visit or date of treatment related to the information you would like to correct. ____

____

8. What is the reason for making this request? ______________________________________

____

9. Please describe how the current information is incorrect or incomplete?

____

____

10. Please attach the written amendment. You may use additional sheets if you like.

11. Do you know of anyone who may have received or relied on the information you want to correct or change (such as your doctor, pharmacist, health plan, or other health care provider)?

____

12. If we make the amendment, do we have your permission to share amendment with individuals who have received this information? ____

____

Signature of patient/legal representative: ____________________________________DATE:________

Witness: ____

****According to NYS Public Health Law § 18, O.A.D.C. will place a reasonable restriction on the time and frequency of any challenges as to accuracy to the medical record.****