# REQUEST FOR AN AMENDMENT OF PROTECTED HEALTH INFORMATION

As a patient of Advanced Practice Nursing Specialists, you have the right to amend incomplete or inaccurate Protected Health Information about you. If you require your Protected Health Information amended, you must complete this for and return it to the Compliance and Risk Manager at the address below.

This request only applies to the Protected Health Information you have provided to Advanced Practice Nursing Specialists, and only the information you provide in the form below will be amended. If you have multiple aspects of your Protected Health Information that are incomplete or inaccurate and require amending, you must complete a separate form for each amendment.

Please complete the following information to amend your Protected Health Information.

Patient Name: _____ Date of Birth: _____

Name of Person completing the amendment form if other than the patient:

_____

Please describe the information you wish to amend:

_____

_____

_____

_____

Please provide a reason to support your requested amendment:

_____

_____

_____

_____

Advanced Practice
Nursing Specialists, LLC
9205 W Russell Rd Suite 305
Las Vegas, NV 89148

info@apnshealth.com
www.apnshealth.com

Please explain how the information is inaccurate or incomplete:

_____

_____

_____

_____

Please state how you would like the information completed or amended:

_____

_____

_____

_____

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

**For Office Use Only**

Date of receipt of amendment: _____

Amendment Denied: _____
Reason for Denial: _____
_____
_____

Amendment Approved: _____
Action Taken: _____
_____
_____

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