GASTRO HEALTH

www.gastrohealth.com

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

By law an individual has the right to amend his or her PHI in the Designated Record Set(s) that Gastro Health, P.L. (Gastro Health) or its Business Associates maintain, as well as to request an amendment to your Protected Health Information (PHI). **If you need assistance completing the form, please contact the Privacy Officer at (305) 913-0682.**

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:
Gastro Health, P.L.: 9500 S. Dadeland Blvd., Suite 200, Miami, FL 33156

Section A: The individual for whom amendment is being requested. Please complete the following:

Name _____ Social Security Number _____ Date of Birth _____

Address _____ City, State, ZIP _____ Telephone Number _____ E-mail address (optional) _____

Section B: Please place an "X" in the box next to the records you are requesting be amended, include specific dates:

Enrollment Records	**From:**	**To:**	**Claim Records**	**From:**	**To:**
☐ Physician Statement Record	_____	_____	☐ Medical	_____	_____
☐ Billing History (if applicable)	_____	_____	☐ Prescription Drugs	_____	_____
			☐ Mental Health	_____	_____

Please state the reason(s) you feel these records should be amended:

_____

Section C: Please list the name(s) and address(es) of individuals to notify should we agree to make the amendment.

Name _____ Name _____

Address _____ Address _____

City, State, ZIP _____ City, State, ZIP _____

Section D: Signature – This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that Gastro Health amend my PHI as specified in Section B above. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature _____ Date: month/day/year _____

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Gastro Health.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City, State, ZIP _____

Personal Representative's Telephone Number _____ Personal Representative's E-mail address (optional) _____