Noel R. Williams, M.D.

Request to Amend Protected Health Information

This form is to be used by patients who wish to request that information kept in the records of Noel R. Williams, M.D. be amended. The following summarizes our policies and procedures with respect to amending patient information:

- Requests to amend information must be submitted in writing.
- Your request will be reviewed by the Privacy Officer and other staff members as appropriate.
- If the Privacy Officer determines that the amendment you have requested should be made, the records will be updated as required by federal regulations.
- If the Privacy Officer determines that the information in our records is complete and accurate, your request will be denied. A written notice of this decision will be sent to you as required by federal regulations. You will have an opportunity to send us a written statement explaining your disagreement with this decision. That statement will be included in your records, along with any response that we believe is necessary to help future users of the information understand that information. You will be given a copy of any response that we include in the record.

Information to Be Amended

Please identify the information you believe needs to be amended in the spaces provided below. Identify the source of the information (for example, your medical records or billing records), the specific information that you believe to be incorrect and the reason you believe the information to be incorrect. If no reason is given, your request will be denied.

If you need help with this form, please contact:

Privacy Officer for Noel R. Williams, M.D.
Phone: 405-715-4496

Information I would like to change: _______________

Data source: ______________________________________

Change: ____

Reason: ____

____

*Response: _______________________________________

____

Noel R. Williams, M.D.

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Information I would like to change: _______________

Data source: ______________________________________

Change: ____

Reason: ____

____

*Response: ______________________________________

Noel R. Williams, M.D.

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Information I would like to change: ______________

Data source: ______________________________

Change: ______________________________

Reason: ______________________________

____

*Response: ______________________________

*Do not complete the response section.

Attach additional copies of this page as needed.

Patient Signature

Please sign and date this form:

____

Name of Patient (Print or Type)

____

Signature of Patient

____

Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

Decision

(For Use By Noel R. Williams, M.D. Only)

Approved Amendments

The following requests for amendment of information have been approved:

- q ______________________________
- q ______________________________
- q ______________________________
- q ______________________________

Noel R. Williams, M.D.

Request to Amend Protected Health Information

This information will be corrected and other organizations to which this information has been disclosed will be notified as required by federal regulations.

Requests for Amendment That Have Been Denied
The following requests for amendment of information have been denied for the reasons given in the response to each of your requests, above:

- q ____
- q ____
- q ____
- q ____

This information will be not amended in our records. If you disagree with this decision, you may submit a written statement of disagreement. Your statement must be limited to one standard letter-sized page (8 inches by 11 inches) per correction. Your disagreement will be included in our records and it, or an accurate summary if it that we will prepare, will be transmitted to any entity to whom the affected information is disclosed in the future. We also may include our own comments on your statement. If we do include such a statement, you will be sent a copy of the statement.

____
Title of Privacy Official

____
Signature

____
Date