Name of Practice: First Internal Medicine, Prof . LLC – Igor Huzicka, MD & Tamara Murphy, PA-C

Request to Inspect and/or Amend Personal Health Records

Patient name: _____ Date of birth: _____

Previous name (if applicable):_____

Address: _____ City: _____ State: _____ ZIP: _____

I. Inspection of My Personal Health Records

I hereby request to make my personal health records available for inspection*. I would like to inspect the following records:

- ❒ All my health information maintained by the above-named practice
- ❒ Other: _____

Please notify me when the records are available** for inspection as follows:

❒ By mail at the address listed above ❒ By phone: _____ ❒ Via email: _____

* Records are available for inspection in our office at 5950 South Willow Drive, Suite 212, Greenwood Village, CO 80111 Monday through Thursday, between 9:00 a.m. and 4:30 p.m. There will be reasonable clerical fees charged if you request a paper copy.

** Records will be available for inspection no later than 30 days after receiving this written request.

II. Amendment /Change to My Personal Health Records (fill out this section only if you request amendments/changes)

Please tell us what protected health information you want to change: _____

_____

_____

_____

Please tell us why you want to make this amendment to your health record (in 250 words or less):

_____

_____

_____

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide. Please tell us where to send you a letter if different from above:

Address: _____

_____

If we decide to change the health information as you requested, we will send the change, upon request, to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information:

- ❒ Yes. Please list names and addresses: _____
- ❒ No. Initials: _____ _____

We will also send the amendment to other persons (upon request) that we know received the information before it was amended if they relied or might in the future rely on the information before it was amended to your detriment (harm). Do you agree to this?

- ❒ No. Initials: _____
- ❒ Yes. Initials: _____

We also wish to inform you that we do not have to change your protected health information if:

1. We did not create the information, e.g. the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has moved, died or is at another practice/office).
2. We believe that the information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.
4. The protected health information you want changed is not part of the designated record set (i.e. medical records; billing records and records containing your protected health information that are used by us to make decisions about you).

If we make a decision not to change your health information, you have the right to submit a statement of disagreement that we must add to your record.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT IN WRITING WITH IGOR HUZICKA, MD, PRIVACY OFFICER FOR FIRST INTERNAL MEDICINE, 4950 SOUTH YOSEMITE ST, STE F2 PMB346, GREENWOOD VILLAGE, CO 80111, OR YOU MAY CONTACT THE OFFICE OF CIVIL RIGHTS AT US DEPARTMENT OF HEALTH AND HUMAN SERVICES (WWW.HHS.GOV/OCR/OFFICE/INDEX.HTML).

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)