SOUND INPATIENT PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
REQUEST FOR AMENDMENT TO PATIENT INFORMATION

I hereby request amendment of the health care information maintained on the following patient:

PATIENT NAME: _____

BIRTH DATE: _____ **PHONE:** _____

ADDRESS: _____

EMAIL: _____

PLEASE DESCRIBE THE HEALTH INFORMATION THAT YOU WOULD LIKE TO HAVE CHANGED OR AMENDED. PLEASE INCLUDE DATES OF SERVICE.

PLEASE EXPLAIN WHY THIS CHANGE OR AMENDMENT IS NEEDED.

PLEASE EXPLAIN WHAT YOU WOULD LIKE TO CHANGE OR ADD TO THE RECORD TO MAKE IT MORE ACCURATE OR COMPLETE.

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I understand that this amendment request will become a part of my medical record. I understand that I will receive a response to my above request within 60 days or I will receive a request for an additional 30-day extension.

_____	_____
Signature of Guardian or Legally Authorized Representative (if patient is a minor or unable to sign)	**Date of Signature**

OR

_____	_____	_____
Signature of Guardian or Legally Authorized Representative (if patient is a minor or unable to sign)	**Date of Signature**	**Description of Authority to Act for the Individual**

_____

Printed Name of Legally Authorized Representative

Authorizations signed by a representative must contain a copy of the guardianship papers or power of attorney.

All requests for amendment must be submitted in writing to:

Chief Compliance & Privacy Officer
Sound Physicians
1498 Pacific Avenue, Suite 500
Tacoma, WA 98402
1(855) 768 6363
Email: compliance@soundphysicians.com