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:_____ SSN:_____

ADDRESS:_____

TELEPHONE:_____

PLEASE DESCRIBE THE HEALTH INFORMATION THAT YOU WOULD LIKE TO HAVE CHANGED OR AMENDED.

_____

_____

_____

PLEASE EXPLAIN WHY THIS CHANGE OR AMENDMENT IS NEEDED.

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

_____

_____

_____

_____

If you are not the patient, please fill out the following information:

Name:_____

Relationship to Patient:_____

Address (if different from above):_____

Telephone (if different from above):_____

Please furnish a copy of any conservator/guardianship papers with this request.

SIGNATURE:_____ DATE:_____

All requests for amendment must be submitted in writing to:

Julie Seitz, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422