

**Notice of Privacy Practices: Attachment A**

**Request To Amend Protected Health Information**

I understand that I have the right to request amendment to incorrect or incomplete protected health information subject to some limitations. I understand that Modern Medical shall respond to my request for amendment in fewer than 60 days from the date of my request. Modern Medical may deny my request to amend my protected health information but I have the right to appeal the denial.

Name: \_\_\_\_\_ Request Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. Identify the specific item (s) in the record that you would like to be changed (amended).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_  
Signature of Injured Worker

**Mail this completed form to:**

**Cory Wedding, Privacy Officer  
Modern Medical, Inc.  
PO Box 549  
Lewis Center, OH 43035**

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*This Section For Modern Medical Use Only:*

Modern Medical, Inc. Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_ Request Denied \_\_\_ Approved as Requested \_\_\_ Approved Per Comments

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injured Worker Informed in Writing (Client Notification of Amendment): Yes \_\_\_

Notification Date: \_\_\_\_\_  
Date Record Amended: \_\_\_\_\_

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