Please print:

First name:	Last name:	Middle init:	Date of Birth:

Street Address:	Apt. #:	City:	State:	Zip Code:

Phone number(s):	Preferred email address:

You have the right to ask for an amendment to your medical record if you feel that an entry is incorrect or incomplete. This right only applies to factual statements in the record and not to a provider's observations, inferences, or conclusions. There are times when NYBC may not allow your record to be changed. In cases where your request to amend your record is denied, you may have NYBC add a statement of disagreement (500 words or less) prepared by you, the patient.

Please describe how your health information record is incorrect or incomplete. Attach any documents you feel are needed to make the entry more accurate or complete.

I understand that my request will be considered, but may not be granted if NYBC determines that my protected health information or record that is subject to this request:

- Was not created by NYBC, unless I provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
- Is not part of my medical or billing record;
- Would not be available for me for inspection under applicable law dealing with access to protected health information; or
- Is accurate and complete.

I understand that I will receive a response within 60 days to amend or reject my request.

Patient/Agent/Surrogate/Guardian* (Signature):	Date:

Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):

***** *The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions.*

Submit completed form to:

New York Blood Center
Attention: Privacy Officer
310 East 67th St
New York, NY 10065

Via **Fax:**
516-478-5040

Via **email:**
PrivacyOfficer@nybc.org

To be completed by NYBC Privacy Officer or Healthcare Provider

☐ Request approved and completed as requested.
Request denied for the following reason: ☐ The health information referenced is not part of the patient's designated record set ☐ NYBC did not create record ☐ Record is not available to the patient for inspection under Federal law ☐ Record is accurate and complete
Comments:

Date request received:	Date notification sent:
Signature:	Date:
Printed name:	Title: