BRONSON	Affix Patient Label

BRONSON HEALTHCARE
ACCEPTANCE OF REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle

_____
Maiden or other name

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

Date of Amendment Request Form: _____ **Date of this Acceptance Form:** _____

Your request to amend your protected health information maintained by BRONSON relating to:
[check the appropriate box]

- ☐ your medical records;
- ☐ your billing records, payment, claims adjudication, case or medical management records;
- ☐ your enrollment, payment, claims adjudication, case or medical management records; or
- ☐ records maintained by or for Bronson to make decisions about you

has been accepted. Please identify on the following line the individual/persons/organization with whom you would like us to share the amendment. By signing this form you give permission for Bronson to release the information.

_____
_____
_____

_____ _____
Signature of patient or patient's Personal Representative Date

_____
Printed name of the person signing and
(if not the patient) the relationship to the patient