



Please send completed form to [webcontact@adrad.com](mailto:webcontact@adrad.com)

**PATIENT REQUEST TO AMEND IMAGING RECORD**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Telephone \_\_\_\_\_ MRN \_\_\_\_\_  
Email \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**I hereby request that my personal health information maintained by Advanced Radiology Partners be revised as described below.** Clearly describe the information to be revised and the reasons you believe the amendments are necessary.

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

**Would you like this amendment sent to anyone else to whom we may have disclosed information in the past?**  Yes (Please specify the name and address below)  No

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

I understand that Advanced Radiology Partners may deny my request to amend health information if it is not in writing and/or does not include my reasons supporting the request. In addition, my request may be denied if the information:

1. was not created by Advanced Radiology Partners, unless I provide reasonable evidence that the person or entity that created the information is no longer available to act on the requested amendment;
2. is not part of my clinical or billing records maintained by or for Advanced Radiology Partners, or used to make decisions about me;
3. is not part of the information that I have a right to inspect and/or copy; or
4. is already accurate and complete as determined by Advanced Radiology Partners.

\_\_\_\_\_  
**Signature of Patient or Patient's Authorized Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Representative (Please print name)**

\_\_\_\_\_  
**Relationship to Patient**

If signed by the patient's representative, please specify the representative's relationship to the patient and authority to act on their behalf. If the patient is a minor (less than 18 years of age) or has a legal guardian, in most cases this authorization must be signed by the patient's parent or legal guardian. If the hospital/provider determines that the minor's consent is necessary to release the requested records, the hospital/provider will contact the minor to obtain his/her authorization.