



### Request for Amendment of Health Information

Individual Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_  
*(include area code)* *(include area code)*

I understand that Alere will notify me in writing of my request no later than sixty (60) days from the date of receipt of my request. If Alere approves my request, I understand that Alere will supplement my record within the timeframe stated above, unless Alere requests a thirty (30) day extension.

1. Describe the information you want amended (e.g. nursing notes) \_\_\_\_\_  
\_\_\_\_\_
2. Date(s) of information to be amended (e.g. date of visit or call) \_\_\_\_\_
3. What is your reason for making this request? \_\_\_\_\_  
\_\_\_\_\_
4. How would you like to change the record? \_\_\_\_\_  
\_\_\_\_\_
5. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist or other health care provider)?  yes  no  
If yes, please specify the name(s) and addresses(s) of the organization or individual  
\_\_\_\_\_

**I understand that Alere may or may not supplement the medical record with an addendum based on my request. I also understand that Alere is not able to alter the original documentation of the medical record. If the requested addendum is made part of my permanent medical record, Alere will make reasonable efforts to inform and provide the addendum within a reasonable time to individuals/organizations identified above as having relied on the content of my medical record, as well as to Alere’s business associates who have relied on the information.**

Name of Individual or  
Personal Representative *(PLEASE PRINT)* \_\_\_\_\_

Signature of Individual or  
Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
(If Personal Representative, include a description of authority to act for individual)

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Please submit this form directly to: Alere Privacy Officer**  
3200 Windy Hill Rd Suite B-100  
Atlanta, GA 30339  
Or fax to 678-279-7538

If you have any questions, please contact the Privacy Officer directly at 770-767-8191

**FOR ALERE USE ONLY**

Amendment has been:  Accepted  Denied

If denied, check the reason for denial:

- Health information was not created by Alere
- Health information is not part of the individual's designated record set
- Federal law forbids making the health information in question available to the individual for inspection
- Health information is accurate and complete
- Originator of the record is not available because \_\_\_\_\_

Staff comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The Privacy Officer Must Review All Denials**

Denial letter sent to individual

Signature of staff person \_\_\_\_\_ Date \_\_\_\_\_

Print Name & Title \_\_\_\_\_