



Request for Amendment of Protected Health Information

Patient's Name:

Last First Middle

Home Address:

Street City State Zip

Home Phone:

Date of Birth:

MRN:

I understand that University Health System may deny this request as permitted under federal law. I further understand that if University Health System denies my request, I will be informed in writing by University Health System of its reason for the denial and what I should do if I disagree with the denial. I further understand that the University Health System will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If University Health System is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.

I hereby request that University Health System amend:

Entry to be amended:

Date and Author of Entry:

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results)

2. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services)

3. What is your reason for making this request?

4. How is the entry incorrect, incomplete, or outdated?

5. What should the entry say to be more accurate or complete? (Please be as specific as possible)

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? Yes No If yes, please specify the name(s) and address(es) of the organizations or individuals(s).

Signature of patient or patient's Personal Representative

Date

FOR UNIVERSITY HEALTH SYSTEM USE ONLY

Amendment has been: Accepted Denied **If denied, check the reason for denial:**

- Protected Health Information was not created by this University Health System
- Protected Health Information is not part of the patient's Designated Record Set
- Protected Health Information is not accessible by the patient under University Health System's policy regarding the patient's right to access his or her Protected Health Information
- Protected Health Information is accurate and complete

Comments _____

Signature of Medical Records Director:

Date