University Health System
Surgery Center – Robert B. Green Campus
Surgery Center – Medical Center
4502 Medical Drive
Medical Records Department MS# 26-2
Phone (210) 358-3532 San Antonio, Texas 78229-4493 Fax (210) 358-5936

Request for Amendment of Protected Health Information

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

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 correct**:** _____
Entry to be corrected: _____
Date of Entry: _____

1. Please tell us what protected health information you want to correct (e.g., procedures, nursing/physician notes, test results)?
_____
_____
_____

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

3. What is the reason for your request? _____
_____
_____

4. How is the entry incorrect? _____
_____
_____

5. What should the entry say? (Please be as specific as possible)_____
_____
_____
_____

6. If your provider authorizes a correction to the health information you requested, University Health System will send the change, upon request, to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information: ☐ No ☐ Yes if yes, please list name(s) and address (es) of the organizations or individuals(s).
_____
_____
_____
_____

_____ _____ _____
Signature of Patient or Patient's Representative Relationship to Patient Date

FOR UNIVERSITY HEALTH SYSTEM USE ONLY **DATE RECEIVED**_____

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 _____
_____

Reviewed by HIM Manager/Medical Records Director: _____ Date_____