



REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name _____ Medical Record # _____

Date of Birth _____ Phone # (____) _____

Patient Address _____

Soc. Sec.# _____ (Providing your SS# is voluntary, but necessary to accurately identify your medical records Failure to provide this information will likely delay the processing of your request).

Approximate Dates of Treatment: _____

I request an amendment to my health information (Note: UUHSC is not permitted to change health information but can amend it). Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page

Signature of Patient or Representative _____ Date _____

If Applicable, Name of Personal Representative* _____

*Description of Personal Representative Authority:

Parent Medical Power of Attorney

Other, explain: _____ and attach documentation.

Signature must be verified by U of U Health staff or notarization may be required. When complete, place in patient's medical record.

• _____ Signature of UUHSC Staff Member _____ Printed Name and Employee ID# _____ Date _____

• SUBSCRIBED AND SWORN before me this ____ day of _____, 20____.

NOTARY PUBLIC

Residing in _____

My Commission expires: _____

University of Utah Health Care Internal Use

- Date Received: _____
- A 30 day extension as been requested. Reason: _____
 - Patient Notified of Extension On: _____
- Request Reviewed by (Provider Name): _____
- Request Reviewed by Provider on: _____
- Request Approved:**
 - Request Approved by Provider
 - Health information updated by provider
- Request denied. Check reason for denial:**
 - The existing health information is accurate and complete.
 - This request does not pertain to the patient's protected health information.
 - Due to federal and state laws this health information is not available.
 - This health information was not created by this organization.
 - The record no longer exists or cannot be found.
 - The record is not maintained by this organization.

Prior to denying an amendment of protected health information, you must notify the University Privacy Office at 7-9241.

- Patient notified of approval or denial:** _____ **(date)**

If your request to amend your protected health information has been denied, you have the right to submit a written statement of disagreement, or file a complaint with UUHSC Customer Service or the Secretary of Health and Human Services.

Statement of Disagreement

To submit a written statement of disagreement, sign here: _____, attach your statement to a copy of this document, and submit to:

Health Information
ATTN: Amendment Denial Review
50 North Medical Drive
Salt Lake City, UT 84132

Filing a Complaint

Contact us at (801) 587-9241, on the Internet at <http://uuhsc.utah.edu/privacy>, or mail us at:

University Privacy Office
650 Komas Drive Suite 102
Salt Lake City, UT 84108

- Request Processed by (Name and Employee ID): _____

When complete, place in patient's medical record. If you have questions, contact the University Privacy Office at 7-9241.