UR Medicine
Health Information Management (HIM) Department
601 Elmwood Avenue, Box 616 • Rochester, NY 14642-8616
Phone: (585) 275-2605 • Fax: (585) 273-1257 or (585) 424-2922

REQUEST FOR AMENDMENT / CORRECTION OF PROTECTED HEALTH INFORMATION

Patient's name (print): _____ MR # (URMC use): _____

Address: _____

City, State & Zip Code: _____

Phone #: (____) _____ Patient Date of Birth: _____

Requestor if not patient (print name): _____

Address, City/State/Zip Code if different: _____

Treatment Location: _____ Treatment Date(s): _____

Date(s) of Entry to be amended: _____

Form/document to be amended: _____

Other information: _____

If you need additional space, please use the back of this form or an additional sheet.

Please explain what information is incorrect or incomplete.

_____

_____

_____

Please provide the information that you feel should be changed or included to make the record accurate or complete.

_____

_____

_____

The reason that this information is inaccurate and that I am making this amendment request is:

_____

_____

_____

I understand that this request is subject to the review of a medical provider who will use his/her professional judgment as to whether or not the record should be amended, and that the original documentation is unable to be removed from my medical record. However, at my request this amendment request and URMC's response may be made part of my medical record and may be sent in response to any authorized requests for my medical information. I will be informed in writing of URMC's response to this request within 60 days, or that an additional 30-day extension is needed to respond as permitted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if signing as authorized representative): _____

UR MEDICINE — INTERNAL USE ONLY

Date received in HIM/Practice: _____ Date provider contacted: _____ Date response due: _____

Outcome of discussion with provider: ☐ Accepted ☐ Denied ☐ Partial Acceptance/Denial

If denied (fully or partially), reason for denial:

☐ PHI is accurate and complete
☐ PHI was not created by UR Medicine
☐ PHI is not part of the patient's designated record set
☐ PHI is not available for inspection as permitted by law

Comments: _____

Written response sent to patient of amendment acceptance or denial on _____

Signature / Title of HIM member processing request: _____ Date: _____

Date Statement of Disagreement received: _____ Date Rebuttal sent: _____