UPMC LIFE CHANGING MEDICINE

PATIENT AMENDMENTS TO PROTECTED HEALTH INFORMATION

REQUEST TO CORRECT/AMEND PROTECTED HEALTH INFORMATION

Patient Name: _____ MRN: _____

Address: _____ _____

SSN: _____ DOB: _____

Origination Facility: _____ Date of entry to be amended: _____

Document to be amended (discharge summary, progress note, etc.)? _____

Reason for requesting the amendment? _____

_____

_____

What changes should be made to the record? _____

_____

_____

Please list any organizations or individuals, along with their addresses, who may have received the information in the past. Should your request for amendment be approved, the amendment will be forwarded to them.

NAME ADDRESS

_____

_____ _____

Signature of Patient or Legal Representative: _____ Date: _____

Patient/Requestor's Phone: _____

For Healthcare Facility Use Only

Date Request Received: _____

Amendment has been: _____ Accepted If accepted, an amendment will be made to the appropriate protected health information

_____ Denied Reason for denial specified below

If denied, check reason for denial:

_____ The protected health information or record was not created by this organization

_____ The protected health information is not part of the patient's "designated record set"

_____ The protected health information or record is not available to the patient for inspection as required by federal law (e.g., psychotherapy notes.)

_____ The protected health information or record is accurate and complete

Comments: _____

_____

_____ _____

Individual Processing Request Date

_____ _____

Signature of Health Care Practioner (if applicable) Date