Health Care Component: _____

Unit Privacy Officer: _____

Amendment/Correction Request Form for Protected Health Information

Instructions: Sections 1-3 must be completed. Please print and sign the form.

Section 1: **PATIENT IDENTIFICATION**

Print Name: _____

Street Address, City, State & Zip Code: _____

Patient's Social Security Number: _____ Date of Birth: _____

Section 2: **RIGHT TO REQUEST**

I understand I have the right to request amendment to my Personal Health Information (PHI) maintained by Health Care Component _____. Pursuant to that right, I hereby request Health Care Component _____ to make the following amendment:

The information I would like to have amended is the following (identify date of entry and attach additional pages as necessary):

I would like this information to be amended in the following manner:

I believe the amendment is necessary for the following reason(s):

If granted, would you like this Amendment sent to anyone to whom we may have disclosed the information in the past?

YES **NO**

If, yes, identify the name and address of the organization or individual:

Section 3: **RIGHT OF DENIAL**

I understand Health Care Component _____ has the right to deny my request for amendment to the extent allowed by law. I also understand that Health Care Component _____ may deny my request for amendment if it is not in writing or does not include a reason to support the request. In addition, Health Care Component _____ may deny my request if the information:

1. Was not created by the provider, unless I provide reasonable evidence that the person or entity that created the information is no longer available to act on the requested amendment;
2. Is not part of my clinical or billing records maintained by or for health care component, or used to make a decision about me;
3. Is not part of the information that I have a right to inspect and copy; or
4. Is already accurate and complete.

_____ ___ /___ /___

Signature of Patient
(If under 18 years if age-Parent, Legal Guardian, or Legal Representative)

Date

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1:

FOR Missouri State USE ONLY

Section 4: **RESPONSE TO REQUEST** Date Received: _____ Initials: _____

Amendment has been: ☐GRANTED ☐DENIED

If denied, check reason for denial:

☐PHI was not created by this organization

☐PHI is accurate and complete

☐PHI is not part of the patient's designed record set

☐PHI is not available to the patient for inspection as required by federal and/or state law

Comments of Health Care Component:

If denied:
If the request is denied, you may file a complaint with the Secretary of the Department of Health and Human Services by calling 877-696-6775, or writing them at 200 Independence Avenue S.W., Washington, DC 20201. You may also file a grievance with the Office of Civil Rights by calling 866-OCR-PRIV (866-627-7748), or TTY at 866-788-4989. You may also file a complaint with the University by contacting the Health Care Component Privacy Officer.

_____ ___ /___ /___

Signature, Name and Title of Staff Member Processing Request Date

A copy of this form will be filed in the above-named patient's PHI.

HIPAA Procedure 1.010, Form 1