UNIVERSITY of ROCHESTER MEDICAL CENTER

Strong Memorial Hospital

Health Information Management Department
601 Elmwood Avenue, Box 616, Rochester, NY 14642-8616
Phone: (585) 275-2605

REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

Patient Name: (please print)	MR #: (URMC use)
Street Address:	Phone #:
City, State & Zip:	
Requestor, if not patient (print name) (address if different than above)	
Patient date of birth:	

Treatment Dates: _____
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 Authorized Personal Representative Date
(if signing as authorized personal representative, describe relationship to patient)

URMC—INTERNAL USE ONLY

Date rec'd in HIM/Practice: _____ Date provider contacted: _____Date response due: _____
Outcome of discussion with provider: ___ Accepted ___Denied ___ Partial Acceptance/Denial
If denied (fully or partially), please check reason for denial:
___ PHI is accurate and complete ___ PHI was not created by URMC
___ PHI is not part of the pt'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 rec'd: _____ Date Rebuttal sent:_____