(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Request for Amendment of Health Information

Patient Name: ______________________ Birth Date: ______________
Patient Account Number: ______________________ Phone: ______________
Patient Address: ______________________
Date of entry to amend: ______________ Type of entry to amend: ______________

Explain how entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

____
____
____

Identify persons who have received health information about you whom you agree need notice of this amendment, if amendment accepted. Please specify the name and address:

____
____
____

(UAMS will identify others whom it knows have health information which need amendment and document such notice.)

______________________ ______________________
Signature of Patient or Legal Representative Print name of Legal Representative

Date: ______________________

If Legal Representative, authority of Legal Representative ______________________
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

* *

Staff Use Only

Date request received: ______________ Amendment: _____ Accepted _____ Denied
Patient notified on: ______________ (must be within 60 days of request). If denied, notify in writing.
Patient notified by: ______________________(Name)

If denied, check reason for denial: _____ PHI was not created by this organization
_____ PHI is accurate and complete _____ Other reason (describe): ______________

Comments, if any: ______________________
____
____

______________________ ______________ ______________
Signature of UAMS Authorized Personnel Date Time

____
(Printed Name)

Med Rec 2347 (01/09)
HIPAA