(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?

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____

____

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