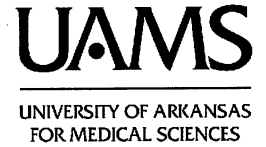


(Place MR Label Here)

MR#:
Patient's Name:
Patient's Address:



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)

