UR Medicine
Health Information Management (HIM) Department
601 Elmwood Avenue, Box 616 • Rochester, NY 14642-8616
Phone: (585) 275-2605 • Fax: (585) 273-1257 or (585) 424-2922

REQUEST FOR AMENDMENT / CORRECTION OF PROTECTED HEALTH INFORMATION

name (print): _____ MR # (URMC use): _____

Address: _____

City, State & Zip Code: _____

Phone #: (____) _____ Patient Date of Birth: _____

Requestor if not patient (print name): _____

Address, City/State/Zip Code if different: _____

Treatment Location: _____ Treatment Date(s): _____

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.

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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 Representative: _____ Date: _____

Relationship to Patient (if signing as authorized representative): _____

UR MEDICINE INTERNAL USE ONLY

Date received in HIM/Practice: _____ Date provider contacted: _____ Date response due: _____