REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION CONTAINED IN A DESIGNATED RECORD SET

Patient's Name: _____
Last First Middle

Medical Record Number: _____

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

The "UC Organized Health Care Arrangement" (or "UC OHCA") consists of The University of Chicago Medical Center ("UCMC"), including its nurses, residents, other staff, and volunteers, the University of Chicago Biological Sciences Division ("BSD") and other portions of the University of Chicago in both cases that supports the activities of Health Care including its physicians, nurses, students, volunteers, and other staff, and UCMC Community Physicians LLC. **Each of these is called a UC Organization.**

I request that UCMC change/amend **[please check all boxes that apply]**:

____ *Medical record*
____ *hospital* ____*outpatient dialysis*
_____ *clinic (name e.g. Neurology):* _____

____ *Billing records*
____ *hospital* _____ *physician (name):* _____

____ *Other (describe in detail):* _____

I understand that:

- UCMC may deny this request as permitted under federal law,
- If UCMC denies this request, they will notify the requestor in writing the reason for the denial and what action can be taken if the requester disagrees with UCMC's decision.
- UCMC will notify the requestor of its decision to accept or deny this request within sixty (60) days of receiving the request. If UCMC is unable to respond to the request within this time frame, it may extend the applicable deadline for up to an additional thirty (30) days by notifying the requestor in writing.

Submit this form to:
University of Chicago Medicine
ATTN: Risk Management & Patient Safety
850 E. 58th Street
MC1135
Chicago, Illinois 60637-1470
Telephone Number: (773) 834-0473

Updated: **February 2, 2016**

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results)

_____

_____

_____

_____

2. List the date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services) _____

3. Why are you making this request? (Be specific. For example, if you say the entry was incorrect, incomplete, or outdated, describe how.)

_____

_____

_____

_____

4. What do you think the entry should say to satisfy your request (e.g. what would make it more accurate or complete? (Please be as specific as possible)_____

_____

_____

_____

_____

5. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? ___ yes ___ no
If yes, list the name(s) and address(es) of the organizations or individuals(s).

_____

_____

_____

_____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

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