



(Patient Identification)

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____
 Patient Address: _____
 Date of Birth: ____/____/____ Medical Record Number _____
 Date of Service to be amended: ____/____/____
 Date of entry to be amended: ____/____/____ Time of entry ____:____ am ; pm
 Type of entry to be amended: _____

After review of my record, I do not feel the original documentation made by _____
 (enter name of health care provider) accurately reflects facts about my condition, diagnosis or treatment
 and should be corrected or clarified in the form of an addendum to my record. I understand the
 physician may or may not agree with my request, and under no circumstances, will alter the original
 documentation in the record. However, this request for an addendum will be made part of my
 permanent record. It will be disclosed as part of the record in response to any authorized releases of my
 medical information. I request the following amendment be made to my record (please explain how the
 entry is incorrect and indicate what the entry should say to be more accurate): If additional space is
 needed, please attach to this form.

_____/____/____ : ____ am
 Signature of Patient (or legal representative [proof required]) Date Time pm

PROVIDING THE AMENDMENT TO ANYONE OUTSIDE OF UCONN HEALTH

Would you like this amendment to be sent to anyone we may have disclosed this information to in the
 past? If so, please specify the name and the address of the organization or individual.

Name of individual/organization: _____
 Address: _____
 Name of individual/organization: _____
 Address: _____

_____/____/____ : ____ am
 Signature of Patient (or legal representative [proof required]) Date Time pm

Original – Medical Record Yellow – Patient

HEALTH CARE PRACTITIONER RESPONSE (UCONN HEALTH USE ONLY)

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

APPROVAL

In response to your request, the amendment will be added to your record.

Amendment Dictation ID #: _____

DENIAL

Your request for amendment has been denied for the following reason(s):

- Personal health information was not created by this organization
- Personal health information is not part of the patient’s designated record set
- Personal health information is not for inspection as required by law (e.g., psychotherapy notes)
- Personal health information is accurate and complete as it stands
- Other _____

Though your request has been denied, the request will be included as part of your medical record.

_____/_____/_____
Signature of Health Information Management Designee Date Time

YOUR RIGHTS AFTER DENIAL OF AMENDMENT

If your request for amendment was denied for any reason stated above on this form, UConn Health is required to inform you of your right to file a disagreement or complaint with this decision.

How to File a Disagreement:

Your statement of disagreement to our denial must be made in writing to the Health Information Department. UConn Health may, upon receipt of your disagreement, write a rebuttal statement. Your statement and any UConn Health rebuttal statement will be kept on file with your record and will be included in any future disclosures of this information. If you do not submit a disagreement statement, you may ask UConn Health to provide a copy of your request for amendment and our denial of that request with any future disclosures of this information that UConn Health makes.

You have the right to complain about the process used to handle your request:

<p>With UConn Health: Privacy Officer UConn Health 263 Farmington Ave. Farmington, CT 06030 Mail Code: 5329 Phone: 860-679-3501</p>	<p>With the Department of Health & Human Services: Regional Manager, Office for Civil Rights DHHS Government Center J.F.Kennedy Federal Building – Room 1875 Boston, Massachusetts 02203 Voice Phone: (800) 368-1019 FAX: 617-565-3809 TDD: (800) 537-7697</p>
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Your complaint must be in writing, filed within one hundred eighty (180) days of when you knew or should have known of the denial, and state that you are complaining against UConn Health.