UCONN HEALTH

(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

HCH1352

UCONN HEALTH

(Patient Identification)

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

HEALTH CARE PRACTITIONER RESPONSE (UCONN HEALTH USE ONLY)

APPROVAL

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

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.

_____	___/___/____	_____:_____ ☐ am
Signature of UConn Health Designee	Date	Time ☐ pm

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 file a complaint with UConn Health and/or the U.S. Department of Health and Human Services Office for Civil Rights:

With UConn Health:	**With the Department of Health & Human Services:**
Privacy Officer UConn Health 263 Farmington Ave. Farmington, CT 06030 Phone: 860-679-7226 Email: privacyoffice@uchc.edu	U.S. Department of Health and Human Services Office for Civil Rights Centralized Case Management Operations 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201 Customer Response Center: (800) 368-1019 Fax: (202) 619-3818 TDD: (800) 537-7697 Email: ocrmail@hhs.gov

A complaint to HHS 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.