

<b>Texas Tech University Health Sciences Center</b>  <b>Request to Amend Protected Health Information</b>	<b>Patient Name:</b> _____  <b>MRN:</b> _____  <b>DOB:</b> _____
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Patient Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

After review of my medical record, I do not feel that the original documentation made by \_\_\_\_\_ accurately reflects my treatment, condition, or diagnosis on the following date \_\_\_\_\_ and should be supplemented with clarifying information in the form of an addendum to my medical record.

I understand that the physician or health care provider may or may not supplement my record with my addendum based on my request. I understand that my physician or other health care provider is not allowed to alter the original documentation in my record. I understand that my request for amendment will be made a permanent part of my medical record and will be sent with any future authorized medical record request for information.

I understand that Texas Tech University Health Sciences Center will provide a response to this request within sixty (60) days. I understand I have the opportunity to provide a statement of disagreement should my physician or health care provider deny my request.

Reason for amendment: \_\_\_\_\_

I request the following correction/amendment be made to my protected health information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date                      Time                      Patient/Other Legally Authorized Person

\_\_\_\_\_  
Witness                      Print Name                      Print Name and Relationship to Patient

### Physician or Health Care Provider Response

\_\_\_\_\_ In response to your request, a correction/addendum will be made part of your permanent medical record.

\_\_\_\_\_ Your request has been denied; however, your request is made part of your permanent medical record. The reason your request is denied:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date response sent to Patient: \_\_\_\_\_ by \_\_\_\_\_