THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER™

Request to Amend Health Information

Please print or type to fill in the following information completely. Incomplete forms cannot be processed.

Today's Date: _____ Patient Name: _____

Patient Date of Birth: _____ Medical Record Number: _____

Patient Address: _____

Describe the information you want amended and the date of the information (e.g., office visits with date of each visit, physician notes with date of the note entry)

_____

_____

_____

What is your reason(s) for making this request?

_____

_____

_____

How is the entry incorrect, incomplete, or outdated?

_____

_____

_____

What should the entry say to be more accurate or complete?

_____

_____

_____

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, please specify the name(s) and address(es) of the organization(s) or individual(s)

_____

_____

_____

Signature of Patient or Legal Representative: _____

Printed name: _____ Date: _____

Relationship to patient: _____

Please do not write below this line. **For UMMC Use only**

Amendment has been: ☐ Accepted ☐ Denied

Reason for denial:

☐ PHI was not created by UMMC

☐ PHI is accurate and complete

☐ Federal and/or State law forbids making the PHI in question available to the patient for inspection

☐ PHI is not part of the designated record set

Staff Comments _____

_____

_____

_____

Signature of Risk Management Staff _____

Print name and title _____