Please complete this form and upload via UHSConnect:
https://uhsconnect.ur.rochester.edu/
Select "Record Amendment Request" & specify UHS or UCC
Please contact hhf@uhs.rochester.edu with any login issues.

REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

Patient's name (print): ____ MR # : _________________
Address: ____
City, State & Zip Code: ____
Phone #: (___) ______________________________ Patient Date of Birth: ___________________________
Requestor if not patient (print name): ____
Address, City/State/Zip Code if different: ____
Treatment Location: __________________________________ Treatment Date(s): _______________________
Date(s) of Entry to be amended: __________________________

Form/document to be amended: ____

Other information: ____

If you need additional space, please use the back of this form or an additional sheet.

Please explain what information is incorrect or incomplete.

____
____
____

Please provide the information that you feel should be changed or included to make the record accurate or complete.

____
____
____

The reason that this information is inaccurate and that I am making this amendment request is:

____
____
____

I understand that this request is subject to the review of a licensed healthcare professional who will use his/her professional judgment as to whether or not the record should be amended, and that the original documentation cannot be removed from my medical record. However, at my request this amendment request and UHS's response may be made part of my medical record and may be sent in response to any authorized requests for my medical information. I will be informed in writing of UHS's response to this request within 60 days, or that an additional 30-day extension is needed to respond as permitted by the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations.

Signature of Patient or Representative: ___________________________________Date: _________________
Relationship to Patient (if signing as authorized representative): ___________________________________

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Date received in HIM/Practice: __________ Date provider contacted: ___________ Date response due: __________

Outcome of discussion with provider: ☐ Accepted ☐ Denied ☐ Partial Acceptance/Denial

If denied (fully or partially), reason for denial:

☐ PHI is accurate and complete ☐ PHI was not created by UHS/UCC

☐ PHI is not part of the patient's designated record set ☐ PHI is not available for inspection as permitted by law

Comments: ____
Written response sent to patient of amendment acceptance or denial on _______________________________
Signature/Title of HIM member processing request: _________________________________Date: __________
Date Statement of Disagreement received: _____________ Date Response sent: _________________