

**REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

UH Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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

Date of entry to be amended: \_\_\_\_\_ Type of entry to be amended: \_\_\_\_\_

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ **Signature of Patient or Legal Representative** \_\_\_\_\_ **Date**

**For UTMB Use Only:**

<b>NOTICE:</b>	
Route this form to Health Information Management after the individual has completed the form.	
Date Received _____ Amendment has been: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied	
If denied, check reason for denial: <input type="checkbox"/> PHI is not available to the patient for inspection as required by federal law (e.g., psychotherapy notes)	
<input type="checkbox"/> PHI was not created by UTMB <input type="checkbox"/> PHI is accurate and complete	
Comments of Healthcare Practitioner: _____	
Name of Staff Member	Title
Signature of Healthcare Practitioner	Date

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

**REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)**

Medical Record Form 7077-3/03  
**The University of Texas Medical Branch Hospitals**  
**Galveston, Texas**

Original-Medical Record

UTMB STRICTLY PROHIBITS CHANGES TO THIS FORM.