UNIVERSITY HOSPITAL
Newark, New Jersey

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 15

1. Today's Date ______________________

2. Patient's Name ______________________

3. Patient's Date of Birth ______________________

4. Patient's Medical Record Number (if known) ______________________

5. Patient's Social Security Number ______________________

6. Describe the information you are requesting to amend: ______________________

7. Date(s) of the information you are requesting to amend: ______________________

8. What is the reason for this request? ______________________

9. Is the information you are requesting to amend: ❑ **Incorrect** ❑ **Outdated** ❑ **Other** (please explain) ______________________

10. What should the information state to be more accurate or complete? ______________________

11. Who, if anyone, received or relied upon the information in question (example: doctor, pharmacist, health plan, etc.)? ______________________

12. Signature of Patient or Legal Guardian ______________________

13. Printed Name of Patient or Legal Guardian ______________________

14. Relationship, if not the Patient ______________________

15. Date ______________________

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

17. The amendment has been: ❑ **Accepted** ❑ **Denied**

18. If denied, indicate reason for denial (please check appropriate box):
    - ❑ Medical Record was not created by this organization
    - ❑ Information to be amended is not part of the patient's designated record
    - ❑ Federal Law prohibits making the question available to the patient for inspection (i.e. psychotherapy notes)
    - ❑ Other (please explain): ______________________

Signature of Authorized Individual ______________________

Date ______________________

Printed Name of Authorized Individual ______________________