UCONN HEALTH

Request for Amendment of the Medical Record

For Health Information Management Office Use Only:

Patient MRN: _____

Date Received: _____

Date Completed: _____

Extension Sent: □ No □ Yes, Date: _____

Circle One: JDH UMG Dental Multiple

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Phone Number: (____)_____-_____

Index to **Request for Amendment**

Submit request to:
UConn Health – Health Information Management
263 Farmington Ave, MC2925
Farmington, CT 06030
Fax: 860-679-1035 – Attn: Amendment Request
Email: amendments@uchc.edu
MyChart: MyChart - Login Page (uconn.edu)

UConn Health upholds the right of individuals (or their legally authorized representatives) to request an amendment or correction to the individual's protected health information (PHI) maintained by UConn Health. UConn Health responds in writing to amendment requests within sixty (60) calendar days after receipt, and UConn Health may notify you of a maximum thirty (30) day extension during this time. A submitted **Request for Amendment of the Medical Record** becomes part of the subject medical record, as does UConn Health's response(s).

UConn Health may deny a requested amendment if the information subject to the request:

- Is determined to be accurate and complete;
- Was not created by UConn Health, and UConn Health is not the custodian of the original record;
- Is not part of the UConn Health designated record set;
- Is contained within a Psychotherapy Note (as defined by 45 CFR 164.501*); or
- Is compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding.

INSTRUCTIONS: ***Complete this form clearly and legibly. Attach additional pages, if needed.***

Date(s) of encounter (appointment, admission, etc.): _____

Record type(s) affected by request (please attach copies, if available):

□ After Visit Summary/Discharge Note
□ History and Physical Exam
□ Plan of Care
□ Procedure Notes
□ Radiology Report
□ Other, describe: _____
□ Progress Notes
□ Provider Notes
□ Pre/Post-Procedure Evaluation
□ Operative Report
□ Laboratory/Pathology Report

Describe the specific information identified as inaccurate or incomplete, the change being requested, and a reason/justification for the request (*if requesting more than one amendment or correction, please number each request and related information*):

Requestor Printed Name: _____ Relationship to Patient: _____

Requestor Signature: _____ Date: _____

If signed by someone other than the patient, provide documentation establishing authority as the patient's legally authorized representative.

**https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.501*

HCH1352