THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete the following:

1. Today's date ______________________
2. Patient Full Legal Name ____
3. Birth date __________________ Patient # ____
4. Patient street address ____

   City___________________________________ State_______________ Zip _______________
5. Describe the information you want added (e.g. lab test results, physician notes)

   ____
6. Date(s) of the information to be added (e.g. date of office visit, treatment, or other services)

   ____
7. What is your reason for making this request? ____
8. How is the entry incorrect or incomplete? ____
9. **Please attach written statement**.
10. 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)? If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

    ____

    ____
11. If we agree to your request, do we have your permission to share the new information with

    individuals who have already received the original information? ___________________________

Signature of patient/legal representative: ____

Individual other than patient: ________________________________ Relationship: _______________

Date: ______________________

FOR HSC USE ONLY

Request for Amendment has been: Accepted Denied

Signature of Privacy Official Designee:_______________________________ Date: _____________________

____ Patient has not filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.

____Patient has filed a Statement of Disagreement that must be released along with other documentation with any future releases of information.

____ Facility/provider appended written response (rebuttal) and forwarded to patient.

____ Facility/provider did not provide a response/rebuttal.