Request for Amendment to Protected Health Information (PHI)

Release of Information Unit – Health Information Management
University of Toledo Medical Center
1015 Research Drive, Toledo, OH 43614
Phone: 419-383-4982 Fax: 419-383-3001

Patient Information	Amendment Information
Patient Name:______________________________	Date of entry to be amended:_______________
Birth Date:_____________ SS#______________	Type of entry to be amended:_______________
Med Record # (optional): ___________________	____
Address:___________________________________	____
___________________________________	Reason for amendment: ___________________________
___________________________________	____
Phone: ____________________________________	____

How is the current information inaccurate or incomplete? (please be specific)

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____

What should the entry say to be accurate/complete? (please be specific)

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____
____

Would you like this information disclosed to any previous recipient of whom this information may have been disclosed to? (include full name and address)

☐Yes ☐No

Name of Recipient: ____

Address of Recipient: ____
____
____

Signed: ______________________________ ____________ ______________________________
(Patient or Authorized Representative) **Date** ***(Witness Optional)***

____
(Relationship to patient and authority to act in the patient's behalf)

UTMC Response to Request

Date of Receipt of Request ________

Your request for Amendment has been ☐granted ☐denied

____
Signature of UTMC Privacy Officer Date

Distribution: Original in chart, copy to the patient