UCR HEALTH
REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: _______________

Address: ____

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Phone: _________________________ Medical Record #: _____________________

What protected health information do you want changed? Please include reasons to support your request (required):

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If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Please list any persons who need the changed information:

☐ Do not send to anyone ☐ Send to the following (list names, addresses and phone #)

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Please note: UCR Health cannot amend your Protected Health Information (PHI) if:

1. The information is accurate and complete.
2. You do not have the legal right to access the protected health information you want changed.
3. We did not create the information, unless the covered entity that created the information is unavailable to act on your request to change it. (If this is the case, please explain above).

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(Signature of Patient or Representative) *Date*

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(Please print name) *Relationship to patient (if other than patient)*

When you have completed this form, please return it to: **University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.**

We will respond to your request within 60 days of receipt