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|  | **The University of Oklahoma** |

**Request for Amendment of Protected Health Information—Health Sciences Center**

NOTICE TO PATIENT: Your request for an amendment to your protected health information maintained in the designated record set is applicable **only** to the information maintained by the University of Oklahoma Health Sciences Center. If you would like to request amendments to your protected health information maintained by any other University entity, a separate request must be submitted to that University entity.

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|  |
| Last Name: |  | First: |  | Middle: |  |
| Other Names Used: |  | Date of Birth: |  |
| Address: |       | City: |       | State: |       | Zip: |       |
| Home Phone: | ( )       |  Alt. Phone: | ( )       |  Cell Phone: | ( )       |
|  |

Address where you want the response to this request sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

**REQUESTED AMENDMENT:**

Date of the record or information you would like amended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the information you would like amended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State the specific reason for requested amendment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request the amendment described above be made to the protected health information in my designated record set maintained or created by the following provider(s) of the University of Oklahoma Health Sciences Center:

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| **Name of Physician or Other Provider** | **HSC Department / Clinic** |
|       |       |
|       |       |
|       |       |
|       |       |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature \*Title, if Legal Representative

**\***May be requested to submit evidence of representative status.

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| [ ]  | **Request APPROVED** |
| **Your request for amendment is approved. Please complete the attached form, Protected Health Information Amendment - Notification Form to identify any persons or entities that need to be notified of the amendment to your protected health information and return the form to us.** |

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| [ ]  | **Request DENIED** |
| **See attached Denial of Request for Amendment of Protected Health Information for details.** |

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129