University HOSPITAL
Newark, NJ

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 15

1. Today's Date

2. Patient's Name

3. Patient's Date of Birth

4. Patient's Medical Record Number (if known)

5. Patient's Social Security Number

6. Describe the information you are requesting to amend:

7. Date(s) of the information you are requesting to amend:

8. What is the reason for this request?

9. Is the information you are requesting to amend: ❑ **Incorrect** ❑ **Outdated** ❑ **Other** (please explain)

10. What should the information state to be more accurate or complete?

11. Who, if anyone, received or relied upon the information in question (example: doctor, pharmacist, health plan, etc.)?

12. Signature of Patient or Legal Guardian

13. Printed Name of Patient or Legal Guardian

14. Relationship, if not the Patient

15. Date

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

17. The amendment has been: ❑ **Accepted** ❑ **Denied**

18. If denied, indicate reason for denial (please check appropriate box):

- ❑ Medical Record was not created by this organization
- ❑ Information to be amended is not part of the patient's designated record
- ❑ Federal Law prohibits making the question available to the patient for inspection (i.e. psychotherapy notes)
- ❑ Other (please explain):

Signature of Authorized Individual

Date

Printed Name of Authorized Individual