HEALTH
UNIVERSITY OF UTAH

PATIENT REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Legal Name of Patient:	Medical Record #:	
Date of Birth:	Phone #:	
Patient Address:		
City:	State:	Zip:
Soc. Sec. # (last 4 digits only):	Approximate Date of Treatment:	

Please explain what information you are requesting to be changed/added to be more complete/accurate.
Include additional pages if needed.

Information requested to be changed must be accompanied by copies of proper documentation/identification

Legal Name of Patient:	*Birth cert, Marriage Lic, Pass Port*
Date of Birth:	*Birth cert, Pass Port*
Address/Phone #:	*GOV. ID*
Social Security #:	*SSN Document Letter*

Signature of Patient or Representative:	Date:	**Representative's Authority:** ____ Parent ____ Medical Power of Attorney ____Other, explain: _____ Please attach documentation
Printed name of Patient or Representative:		
Signature of UUHC Staff Member	UNID or Printed Name	Date:

Notary Public
Name: _____

SUBSCRIBED AND SWORN before me this ___ day of _____, 20____
Residing in: _____My Commission expires: _____

To be completed by UUHC

Correction/Amendment has been ☐ Accepted ☐ Denied ☐ Delayed until _____

If your request to amend your protected health info has been denied, you have the right to submit a written statement of disagreement, or file a complaint with UUHSC Customer Service or the secretary of Health and Human Services. Attach a written statement of disagreement and sign below.

X _____

Statement of Disagreement	**File a Complaint**
HIPAA Regulatory Office ATTN: Amendment Denial Review 50 N Medical Drive, SLC, UT 84132	(801)581-2668 UUHSC Customer Service 50 N Medical Drive, SLC, UT 84132