



Patient's Request for an Amendment of Protected Health Information

PATIENT'S REQUEST

Effective \_\_\_\_\_ (date) I, \_\_\_\_\_ (print full name) am requesting that protected health information or a record contained in my designated record set be amended as follows.

Patient's Name (Please Print) \_\_\_\_\_

Mailing Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Please provide as much information as possible about the records you want amended, such as (1) the date of the record(s); (2) the physician who or the University Hospitals facility that created the record(s); (3) the exact language that you wish to be amended and (4) the reason for the amendment request. If you have a copy of the record(s) that you would like to be amended, please send a copy along with your completed request form. This information will assist us in locating the record(s) at issue and following up with the appropriate individuals.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[ ] Additional pages attached

If UH grants all or part of your request, please list all the persons and entities (including addresses) that you want UH to notify of the change(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

OR Patient's Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Representative's Relationship to Patient: \_\_\_\_\_

This request must be sent to:  
UH Privacy Officer:  
3605 Warrensville Center Road, Mail Stop #MSC 9105 - Shaker Heights, OH 44122  
You may also email your request to [Compliance@UHospitals.org](mailto:Compliance@UHospitals.org).