NORTHERN ARIZONA UNIVERSITY

HIPAA Privacy Office
Old Main
PO Box4083 928-523-6347
Flagstaff, AZ 86011-4083 928-523-9377 fax

NORTHERN ARIZONA UNIVERSITY
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION FORM

_____ _____/_____/_____
Name (Please Print) Date of Birth (MM/DD/YY)

_____ _____
Emplid (University ID#) Phone Number

_____
Street Address

_____
City/State/Zip

_____
Name of the Northern Arizona University Department or Clinic

Date of entry to be amended: _____ Type of entry to be amended:_____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____
_____
_____

I authorize the release of the amended information described on the form to the following parties (additional parties can be listed on the back of this form):

_____
Name

_____
Address City State Zip

_____
Signature of Patient or Personal Representative Date

You have the right to submit a Health Record Amendment/Correction request to be made a part of your health record. This request will not later or change the original record created by your physician or health plan, but will supplement the record. We may deny your request to amend or correct your records. All decisions will be provided to you in writing within 60 days of receipt of your request.