HIPAA Privacy Office
Babbitt Administration
Building 51, Room 100
P.O. Box 4116
Flagstaff, AZ 86011-4116
928-523-6347

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION FORM

Name (please print): _____

Date of Birth: _____

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 last page 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 alter 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 the receipt of your request.

I authorize the release of the amended information described on the form to the following additional parties:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____