(Place MR Label Here) MR#: Patient's Name: Patient's Date of Birth:



Request for Amendment of Health Information

Patient Name:	Birth	date:	
Patient Account Number: Phone:			
Patient Address:			
Date of entry to amend:	Type of entry to ar	mend:	
Explain how entry is incorrect or incomplete	. What should the entry say to be	more accurate o	r complete?
Identify persons who have received health in amendment accepted. Please specify the national description of the property of th		agree need notic	e of this amendment, if
(UAMS will identify others whom it knows ha	ave health information which nee	d amendment ar	nd document such notice.)
Signature of Patient or Legal Representative	Print name o	Print name of Legal Representative	
Date:			
If Legal Representative, authority of Legal Re (such as parent of a minor, court-appointed with power of attorney, or healthcare proxy) * * * * * * * * * * * * * * * * * *	guardian, administrator of estate	of deceased, atto	orney-in-fact appointed
	Staff Use Only		
Date request received:	Amendment:	Accepted	Denied
Patient notified by:	(must be within 60 days of r	equest). If denie	d, notify in <u>writing</u> .
If denied, check reason for denial: PH PHI is accurate and complete	•		
Comments, if any:			
Signature of UAMS Authorized Personnel		Date	Time
Printed Name			

