REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

MICHIGAN STATE UNIVERSITY HEALTHTEAM

Patient Name:_____ Date of Birth:_____

Address:_____ Phone Number :_____

What information are you requesting to be amended? _____

_____

_____

What is your reason for making this request?

_____

_____

If you would a copy of your medical records, please complete the "Patient Authorization for Disclosure of Health Information" form available on the www.HealthTeam.MSU.edu website or by calling the Health Information Management office at (517) 353-4905.

I acknowledge that the health care provider may or may not supplement the medical record with an amendment based on my request, and under no circumstances is able to alter the original documentation of the medical record. This request for an amendment will be made part of my permanent medical record and will be sent to individuals/organizations identified above.

Patient Signature: _____ Date:_____

RETURN THE COMPLETED FORM TO:

MSU HealthTeam Privacy Officer
West Fee Hall MSU
909 Fee Road
East Lansing, MI 48824-1315

For MSU HealthTeam Use Only

Date Request Received:_____ MRN Number: _____

(Circle One) Accepted Denied. Reason for Denial:_____

Comments:_____

_____

_____

Signature of Author/Provider: _____

Date amendment was documented: _____

Date patient was notified: _____

Date amended information was sent (see above);_ _____

Comments: _____

_____

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