UofL Physicians

HIPAA REQUEST FOR AMENDMENT

Patient Name _____ Date of Birth _____
Last First MI

Patient Address _____

I am requesting an amendment of the following information in my medical record.
Please note reason for the request:

_____
_____
_____
_____
_____
_____

Date(s) of the information you are asking to amend:
_____

I understand that my request may be denied. I understand that my healthcare provider is not allowed to alter the original documentation in my record. I understand that request may become a permanent part of my medical record and will be sent with future medical record request. I understand that I have the opportunity to provide a statement of disagreement should my request be denied.

The University of Louisville Physicians, Inc. (UofL Physicians) Privacy Officer will notify you, in writing, within 60 days of the above request to inform you of the decision.

Please mail request to UofL Physicians Privacy Officer, P.O. Box 909, Louisville, KY 40201-0909. You may call (502) 588-4520 or (855) 588-6001 for any questions you may have.

Signature of Patient or Legal Representative _____ Date _____
(Must provide written proof of legal status)

If Legal Representative, Print Name_____

Signature of UofL Physicians Representative _____ Date _____

For UofL Physicians Use Only

Date Request Received _____

☐ Accepted ☐ Denied

Date Reply Mailed to Patient/Patient's Legal Representative _____

Refer to amendment reply for reason for denial.