Patient Address: ________________________________________________________________
Patient Phone Number: ________________________________________________________

After a review of my medical record, I do not feel that the original documentation made by ___________________________ accurately reflects my treatment, condition, or diagnosis on the following date ___________________________ and should be supplemented with clarifying information in the form of an addendum to my medical record.

I understand that the physician or health care provider may or may not supplement my record with my addendum based on my request. I understand that my physician or other health care provider is not allowed to alter the original documentation in my record. I understand that my request for amendment will be made a permanent part of my medical record and will be sent with any future authorized medical record request for information.

I understand that Texas Tech University Health Sciences Center El Paso will provide a response to this request within sixty (60) days. I understand I have the opportunity to provide a statement of disagreement should my physician or healthcare provider deny my request.

Reason for amendment: ______________________________________________________________________________________________________

I request the following correction/amendment be made to my protected health information:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Date ____________________________ Time ____________________________ Patient/Other Legally Authorized Person ______________________________________
Witness __________________________ Print Name __________________________ Print Name and Relationship to Patient ______________________________________

Physician or Health Care Provider Response

In response to your request, a correction/addendum will be made part of your permanent medical record.

Your request has been denied; however, your request is made part of your permanent medical record. The reason your request is denied: ____________________________________________
____________________________________________________________________________
____________________________________________________________________________

Signature: ____________________________ Date: ____________________________

Date response sent to patient: ____________________________ by ____________________________________________

HPP 7.3_TTUHSC El Paso Request to Amend Protected Health Information

Attachment A

January 23, 2024