Patient Address: ________________________________

Patient Phone Number: _________________________

After 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 health care 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

November 17, 2020