OFFICE OF
HIPAA
COMPLIANCE
CENTRAL MICHIGAN UNIVERSITY

Request to Amend Protected Health Information

I understand that I have the right to request an amendment to my health information if I believe it is incorrect or incomplete, subject to some limitations. I understand CMU shall respond to my request for amendment in fewer than 60 days from the date of my request. CMU may deny my request to amend my protected health information, but I have the right to a statement of CMU's disagreement placed in my records.

Name: _____ Date: _____

Address: _____ Telephone: _____

_____

Select the clinic(s):

☐Carls Center for Clinical Care and Education

☐Injury Care Center

☐Athletics Sports Medicine

☐University Health Services

☐ Center for Community Counseling and Development

☐Other, please list below

Identify the specific item(s) in the record that you would like to be changed (amended).

_____

_____

_____

_____

_____

(Use additional pages if necessary.)

_____ _____

Client/Patient/Employee Signature Date

_____

Guardian Signature, if appropriate

_____

Relationship to Client

- -

(For office use only)

___ Request Denied ___ Approved as Requested ___ Approved Per Comments

Comments:

_____

_____

_____

_____

_____

_____

HIPAA Privacy Officer Signature:_____

Review Date: _____

Client Informed: Yes ___ No ___ Contact Date:_____

Contact Method:_____