UCLA Health

MRN:
Patient Name:

(Patient Label)

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: _____ MRN: _____

Address: _____
(street, city, state, zip)

Date of Birth: _____ Phone: _____

Email: _____

What protected health information do you want changed? Please include a detailed explanation and reasons to support your request (required). Please include the date of admission or treatment, if known:

_____

_____

_____

_____

_____

☐ If your request is related to billing or coding, please check here

If we decide to change the health information as you requested, please list any person(s) who need the changed information:

☐ Do not send to anyone

☐ Send to the following:

1. Name: _____

Address: _____
(street, city, state, zip)

Email: _____ Phone: _____

2. Name: _____

Address: _____
(street, city, state, zip)

Email: _____ Phone: _____

Please note: UCLA Health cannot amend your Protected Health Information (PHI) if:

1. The information you wish to be amended is accurate and complete.
2. You do not have the legal right to access the protected health information you want changed.
3. We did not create the information.
4. The information you want changed is not part of your Designated Record Set (medical record, billing record and information use to make decisions about you).

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Patient or Representative Signature		Date	Time

If signed by someone other than the patient, please specify relationship to patient: _____

Interpreter Signature	Interpreter ID #	Date	Time

When you have completed this form, please return it to:
UCLA Health Information Management Services
Attention: HIMS Director
10833 Le Conte Avenue, CHS BH–921
Los Angeles, CA 90095–7305
Fax to: 310-794-1616
Email to: PatientID@mednet.ucla.edu
Questions: 310-825-6021 | 310-825-7818 | 310-794-1609

We will provide a written response to your request within 60 days after receipt of request.