SUNY DOWNSTATE Medical Center

PATIENT REQUEST FOR AMENDMENT OF HEALTH INFORMATION

As our patient, you have the right to request that we amend most information in our records that may be used to make decisions about you or your treatment for as long as we maintain that information.

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone:

_____ _____ (daytime)

_____ _____ (evening)

What information would you like to amend?

_____

_____

_____

_____

How do you believe the information should be amended?

_____

_____

_____

_____

Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request.

_____

_____

_____

_____

If your request is being made because of an emergency, please state the date you need the information. We will do our best to accommodate your request: _____

By signing below, I certify that I am requesting that SUNY Downstate Medical Center University Hospital of Brooklyn amend my health information as stated above.

_____ _____

Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____

Description of Personal Representative's Authority Date

FOR SUNY DOWNSTATE USE ONLY- To be completed by appropriate staff member:

Date Request Received: (MM/DD/YY) ___/___/___

Disposition of Request:

__ Granted

__ Denied

__ Partially Denied

Date Patient Notified of Response: (MM/DD/YY) ___/___/___

_____ _____

Name of SUNY Downstate Staff Member Date