SUNY DOWNSTATE Medical Center

NOTICE OF APPROVAL OF AMENDMENT

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request For Amendment Of Health Information

Dear [Patient Name]:

This letter responds to your request that we amend your health information, which we received from you on _____. We agree to make the amendment that you have requested. Your records will be updated accordingly.

If you agree, we will also notify other people or organizations about this amendment that may rely on the original un-amended information they currently have in a way that may negatively affect you. In addition, we will notify others that you identify that may have the original un-amended health information.

Please check the appropriate box(es) below and return within 10 days to:
SUNY Downstate Medical Center University Hospital of Brooklyn
Department of _____- Box #_____
Correspondence Unit
450 Clarkson Ave.
Brooklyn, NY 11203

As always, we are committed to helping you assure that the information about you is kept accurate. Thank you for your assistance and patience in helping us achieve this goal.

TO BE COMPLETED BY THE PATIENT:

- ❑ Notify others that SUNY Downstate knows has my original health information that can negatively affect me.
- ❑ Notify others whom I know have the original information. Specify name(s), address and phone number(s):

_____
_____
_____
_____

_____ _____
Signature of Patient or Personal Representative Date