



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 University Physicians of Brooklyn, Inc. 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 UPB 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 UPB Staff Member

Date