UMASS MEMORIAL HEALTH

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

☐ UMass Memorial Medical Center
☐ UMass Memorial - Harrington Hospital
☐ UMass Memorial HealthAlliance-Clinton Hospital
☐ UMass Memorial - Marlborough Hospital
☐ UMass Memorial Medical Group - Location: _____

NAME:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

HAR / CSN ACCOUNT NUMBER:

PRINT CLEARLY IN INK OR APPLY PATIENT LABEL

Patient Name	Date of Birth
Address	Medical Record Number

I hereby request that UMass Memorial Health Care (UMMHC) make the following changes to my medical or billing record:

_____

_____

_____

_____

The reason for my request is:
☐ Information is incomplete.
☐ Information is not accurate.
☐ Other (describe if not included above): _____

_____

I understand that it may take up to 60 calendar days, from the date UMMHC receives my request, to process my request. I also understand that UMMHC may require an additional 30 days to process the request, provided I am notified of the reason for the delay or the expected completion due.

I further understand that UMMHC may deny my request to amend my record for any of the following reasons:

- ◇ UMMHC did not create the record in question, or;
- ◇ The protected health information is not part of a designated record set that is available for inspection, or;
- ◇ UMMHC determines that the information in dispute is accurate and complete.

I also understand that if my amendment is denied, I will receive notification in writing. I may submit a statement of disagreement if my amendment is denied. I may request that all future uses or disclosures of the disputed information include my request, the denial, my statement of disagreement (should I choose to submit one) and the UMMHC rebuttal to my statement of disagreement (if applicable).

I understand that if my request is denied, I can complain to the Privacy Officer at the address noted below and/or the Department of Health and Human Services in Washington, D.C.

I agree to have UMMHC forward my request for amendment (and denial, statement of disagreement and rebuttal if applicable) to UMMHC business associates who may process my information on behalf of the facility.

_____ _____ _____
Signature of Patient/Parent/Legal Representative* Printed Name Date

Signer's Relationship to Patient:_____

If signing as a legal representative, also provide appropriate paperwork to support status.

_____ _____ _____
Signature of Witness Printed Name Date

Identification (for UMMHC use only): _____

Please forward the completed form to the applicable facility below or the medical practice where you receive care.

FOR CHANGES TO MEDICAL OR BILLING RECORD:

UMass Memorial Health Care
C/O Health Information Management
67 Millbrook Street, Suite 200
Worcester, MA 01606
Tel 508-334-5700 opt. 1

FOR COMPLAINTS:

UMass Memorial Health Care
C/O Privacy Office
Biotech One, 365 Plantation Street, Suite 315
Worcester, MA 01605
Tel: 508-334-1418