TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO

Patient Name: _____

MRN: _____

DOB: _____

Patient Address: _____

Patient Phone Number: _____

After review of my medical record, I do not feel that the original documentation made by _____ accurately reflects my treatment, condition, or diagnosis on the following date _____ and should be supplemented with clarifying information in the form of an addendum to my medical record.

I understand that the physician or health care provider may or may not supplement my record with my addendum based on my request. I understand that my physician or other health care provider is not allowed to alter the original documentation in my record. I understand that my request for amendment will be made a permanent part of my medical record and will be sent with any future authorized medical record request for information.

I understand that Texas Tech University Health Sciences Center El Paso will provide a response to this request within sixty (60) days. I understand I have the opportunity to provide a statement of disagreement should my physician or health care provider deny my request.

Reason for amendment: _____

I request the following correction/amendment be made to my protected health information:

_____

_____

_____

_____

Date	Time	Patient/Other Legally Authorized Person
Witness	Print Name	Print Name and Relationship to Patient

Physician or Health Care Provider Response

_____ In response to your request, a correction/addendum will be made part of your permanent medical record.

_____ Your request has been denied; however, your request is made part of your permanent medical record. The reason your request is denied:

_____

_____

_____

Signature: _____ Date: _____

Date response sent to patient: _____ by _____