UVA Health

1500000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, W RITE IN PT NAME & MR#

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Return form to:
UVA Health System
Release of Information, Health Information Services
P.O. Box 800476
Charlottesville, VA 22908-0476

Patient's Name:_____ Date of Birth: _____

Patient's Address: _____

MRN: _____Phone number: _____

Date(s) of Information to be amended: _____

Type of entry to be amended: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____

_____

_____

_____

_____

Do you know of anyone who may have received the information in question? (Doctor or other health care provider?)

☐yes ☐ no

If yes, please specify the name(s) and address (es) of the organization(s) or individual(s)

_____ _____ _____

_____ _____ _____

_____ _____ _____

I understand the health care provider may or may not supplement the medical record with an addendum based on my request, and under no circumstance, is able to alter the original documentation of the medical record. If the request is accepted, I agree to have the Health System make reasonable efforts to provide the addendum to the individuals/ organizations identified above.

_____ _____

Patient or Legal Representative Signature Date

For Health System Use Only

Date Form Received: _____