UCLA Health

MRN:
Patient Name:

(Patient Label)

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Name: ____ Date of Birth: _____________

Address: ____

Phone: _____________ Medical Record # : ________________

What protected health information do you want changed? Please include reasons to support your request (required):

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If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Please list any persons who need the changed information:

☐ Do not send to anyone ☐ Send to the following (list names, addresses and phone #)

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Please note: UCLA Health cannot amend your Protected Health Information (PHI) if:

1. The information is accurate and complete.
2. You do not have the legal right to access the protected health information you want changed.
3. We did not create the information, unless the covered entity that created the information is unavailable to act on your request to change it (If this is the case, please explain above).
4. The information you want changed is not part of your Designated Record Set (medical record, billing record and information use to make decisions about you).

Patient or Representative Signature _________________________ Date ______ Time ______

If signed by someone other than the patient, please specify relationship to the patient: __________

When you have completed this form, please return it to Health Information Management Services, Attention HIMS Director,
10833 Le Conte Avenue, CHS BH–921 Los Angeles, CA 90095–7305