



Release of Information

## 5802894 – Request for Amendment/Correction to Medical Record

**Please complete, sign and return this form to:**

Health Information Management  
Document Imaging  
33 Lewis Road, 1st Floor  
Binghamton, NY 13905

**Or submit via fax to 607-762-2138**

(Internal: 22138)

Contact us at 607-762-2112 (Internal: 22112)

**Medical Record Number:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
Last Name First Name Middle

**Address:** \_\_\_\_\_  
Street City State/Zip Code

**Date of Request:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Telephone:** (\_\_\_\_) \_\_\_\_-\_\_\_\_

*I request that the following information be amended/corrected in my record. (What should the entry say to be more accurate or compete?) Please specify the respective date(s) of service. I request a change to my record(s) for my visit to \_\_\_\_\_  
(physician department or clinic name or office location)*

**I request the following change be made:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I request the change because:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like the amendment/correction sent to anyone to whom we may have sent the information in the past? If so, please specify:

**Name/Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Original to Record**

**Please Maintain a Copy of this Form for your patient records**

rev 7.19, rev 12.18, ini 3.17



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I understand that I will receive a copy of this form and that my request will be processed in 60 days or I will be informed of the need for an extension of not more than 30 days to process the request.

I understand that I may ask for my request for amendment/correction to be included in any disclosure of the information to which the disagreement relates.

**Copy of the Document in Question Attached:** ☐ Yes ☐ No

**Do you want a copy of your corrected record:** ☐ Yes ☐ No

\_\_\_\_\_  
**Patient/Legal Representative Signature** **Date** **Time**

**Relationship to Patient:** \_\_\_\_\_

**Section II: Completed by UHSH Authorized Personnel**

**Request Approved:** ☐ Yes ☐ No **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time:** \_\_\_\_\_

**Request Approved by (Print Name):** \_\_\_\_\_

**If yes, updated document(s):** ☐ Paper Record ☐ Electronic/Online Record ☐ Both

**Healthcare Practitioner's Comments/Special Instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If no, why?**

☐ Not created by UHSH ☐ Not a part of Medical or Billing Record ☐ Is accurate and complete

☐ Information contains information which could jeopardize safety of patient or others

☐ Information is part of patient's past medical history

☐ Other: \_\_\_\_\_

**If your request has been denied:**

- You may submit a statement disagreeing with the denial.
- You may request that your original amendment/correction request and denial be attached to future disclosures of your protected health information.
- You may file a complaint with UHSH Privacy Officer at the number below, or with the Secretary of Health & Human Services.

**Date notice sent to requestor:** \_\_\_\_\_

\_\_\_\_\_  
**UHSH Representative Signature** **Date** **Time**

**Privacy Officers:**

**UHS Hospitals** Nancy Rongo 763-5060 (Internal: 35060)

**UHS Medical Group** Denise Wieber 251-2962 (Internal: 12962)

**UHS Chenango Memorial Hospital** Wendy Surdoyal 337-4138 (Internal: 74138)

**UHS Delaware Valley Hospital** Lisa Moffett 865-2203 (Internal: 52203)

**UHS Home Care** Paula Joyce 763-8950 x43314 (Internal: 38950)

**UHS Senior Living at Ideal** Marilyn Barbieri 786-7307 (Internal: 67307)

**UHS Hospitals Privacy and Security Administrator** Deborah Tokos 762-3335 (Internal: 23335)

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