UMC
UNIVERSITY MEDICAL CENTER

* A M E N D *

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

MRU01840 (02/10/22)

PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW:

Patient Name:_____

DOB:_____ Age:_____ Sex:_____

CSN:_____

MRN:_____

Instructions: Please complete and submit this form with all required attachments to the department of Health Information Management (HIM) at University Medical Center of Southern Nevada (UMC).

Patient's Full Name:_____ Date of Birth:_____ Sex:_____

Photo ID # & State of Issuance:_____ Last 4 digits of patient's Social Security #:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Date of entry to be amended:_____ Account #:_____ Medical Record #:_____

Type of Encounter *(ex. Emergency Department visit, Clinic visit, etc.)*:_____

Type of entry to be amended *(ex. Progress Note, Transcribed report, etc.)*:_____

Please explain how the entry is incorrect or incomplete and specify what it should say to be more accurate or complete *(If you need additional space, please attach another sheet of paper):*

_____

_____

_____

_____

_____

Would you like this amendment to be sent to anyone whom we may have disclosed this information to in the past? If so, please specify the name(s) and address(es) of the organization(s) or individual(s) below.

_____

_____

Required attachments:

- ❑ A printed copy of the part of the medical record to be amended, with the specific PHI clearly marked
- ❑ A photocopy of the patient's photo ID (and the requestor's photo ID, if requested by a legal representative)

Use one of the following methods to submit a completed request and all required attachments:

- Mail to: 1800 W. Charleston Boulevard, Las Vegas, Nevada 89102-2386 *(Attention: HIM)*
- Walk-in: HIM Department at the above address, Monday - Friday from 8:00 a.m. - 4:30 p.m.
- Fax to: 702-207-8330 *(Attention: HIM)*
- Email: HIMManagementAnalysts@umcsn.com

By signing below, I understand UMC may or may not amend my Protected Health Information (PHI) based on this request and that the original entry(ies) in the record will not be altered. Additionally, I also understand that this request will be made a part of my permanent medical record. Please call 702-383-2228 with any questions.

Time:_____ Date:_____ Signature of Patient or Legal Representative:_____

Relation to patient:_____ Name, if signed by Legal Representative:_____