

**Yale University School of Nursing Form  
Request Amendment of PHI Retained in Designated Record Set**

PATIENT NAME: \_\_\_\_\_  
LAST                      FIRST                      MI                      MAIDEN OR OTHER NAME

DATE OF BIRTH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_                      MEDICAL RECORD #: \_\_\_\_\_  
MO    DAY    YR

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

ENTRY TO BE AMENDED:  
 DATE: \_\_\_\_\_ TYPE: \_\_\_\_\_

Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (You may attach one typed page of at least 10-point font to this document.)

\_\_\_\_\_

\_\_\_\_\_

If granted, would you like this amendment sent to anyone whom we may have disclosed the information in the past? If so, Please specify the name(s) and address(es) below. Attach a form to this indicating additional names and addresses.

Name of Person or Entity	Address	Yale Use: Date of Disclosure	Signature of Yale Staff

I understand that if granted, Yale will notify other persons or Business Associates it knows who have my PHI that needs to be amended and have relied or may rely on it to the detriment of myself.

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

I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement of disagreement to the Yale School of Nursing, Office of Clinical Affairs, 100 Church St. South, P.O. Box 9740 New Haven, CT 06536-9740. My written statement must be contained on one typed page of at least 10-point font.

If I do not submit a written statement of disagreement, I understand that I may request that the request for amendment and the denial be disclosed with any future disclosures of the information that is the subject of the amendment. My request for this type of disclosure should be in writing to Yale School of Nursing, Office of Clinical Affairs, 100 Church St. South P.O. Box 9740 New Haven, CT 06536-9740.

I understand that I may file a complaint concerning my request for amendment within 180 days of making the request to:  
 Privacy Officer  
 Yale University  
 P.O. Box 208337  
 New Haven, CT 06520-8337

Or you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.

\_\_\_\_\_  
SIGNATURE OF PATIENT                      DATE                      OR                      PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON                      DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT