Yale University Form

Request Amendment of PHI Retained in Designated Record Set

Name of Patient _____ **MRN#** _____

Date of Birth _____ **Daytime Phone #** _____

Address _____ **Evening Phone #** _____

City _____ **State** _____ **Zip Code** _____

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 indicating additional names and addresses.

Name of person or entity	Address	Yale use: disclosure date	Yale signature

I understand that if granted, Yale University 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 contained on one typed page of at least 10-point font; OR if I do not submit a written statement of disagreement, I understand that I may ask that my request for amendment and the denial be disclosed with any future disclosures of the information that is the subject of the amendment. My statement of disagreement or request for this type of disclosure should be in writing to the Privacy Officer listed below.

I also 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 208252
New Haven, CT 06520-8252

Or you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Contact our Privacy Office at 203-432-5919 to obtain this address.

_ _____ _____ OR _____ _____

Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____

Relationship to Patient

Original Date of Form: Effective Date: April 14, 2003
Revised Date: September 19, 2012