THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Request for Amendment to Protected Health Information (PHI)

Release of Information Unit – Health Information Management
University of Toledo Medical Center
1015 Research Drive, Toledo, OH 43614
Phone: 419-383-4982 Fax: 419-383-3001

Patient Information	Amendment Information
Patient Name:_____	Date of entry to be amended:_____
Birth Date:_____ SS#_____	Type of entry to be amended:_____
Med Record # (optional): _____	_____
Address:_____	_____
_____	Reason for amendment: _____
_____	_____
Phone: _____	_____

How is the current information inaccurate or incomplete? (please be specific)

_____
_____
_____
_____
_____

What should the entry say to be accurate/complete? (please be specific)

_____
_____
_____
_____
_____
_____

Would you like this information disclosed to any previous recipient of whom this information may have been disclosed to? (include full name and address)

☐Yes ☐No

Name of Recipient: _____

Address of Recipient: _____
_____
_____

Signed: _____ _____ _____
(Patient or Authorized Representative) Date *(Witness Optional)*

_____
(Relationship to patient and authority to act in the patient's behalf)

UTMC Response to Request

Date of Receipt of Request _____

Your request for Amendment has been ☐granted ☐denied

_____
Signature of UTMC Privacy Officer Date