Baylor College of Medicine

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH	LAST 4 OF SOCIAL SECURITY #

PATIENT ADDRESS

PATIENT PHONE/E-MAIL:

NOTICE You have the right to request to have information in your medical record changed. Baylor College of Medicine (BCM) has a period of 60 days from receipt of this request to respond. The original information contained in your record will not be erased or obliterated as a result of any change made by BCM. Once review is complete, the original of this form will be maintained in your medical record and a copy will be provided to you.	MAIL COMPLETED FORM TO: **Baylor College of Medicine** **Attn: Release of Information** **2 Greenway Plaza, Suite 900** **Houston, TX 770546** **713-798-5259 (Phone)** **713-798-1464 (Fax)**

DATE OF ENTRY TO BE CORRECTED/AMENDED:

INFORMATION TO BE CORRECTED/AMENDED:

Please explain how the entry is incorrect or incomplete. What should the entry state to be more accurate or complete? If you have a copy of the record, please make proposed changes and attach. Attach additional sheets if needed.

Name and address of who you would like BCM to notify of any change, **if it is accepted**.

NAME	**ADDRESS**

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE*	DATE

****

FOR BCM USE ONLY

DATE RECEIVED:	REQUEST HAS BEEN	☐ Accepted	☐ Denied
		☐ Partially Accepted	☐ Partially Denied

CHECK REASON FOR DENIAL, PARTIAL DENIAL/ACCEPTANCE:	☐ PHI is not part of the patient's designated record set	☐ Record is not available to the patient for inspection under Federal law
	☐ BCM did not create the record	☐ The record is accurate & complete

SIGNATURE OF HEALTH CARE PROFESSIONAL:	DATE:

PATIENT NOTIFIED DATE		BY:

If BCM denies your request, in whole or in part, you have the following rights:

- Submit a written statement of why you disagree with the denial and send it to the address listed above.
- Request that your provider disclose this Request for Amendment and the denial with any future disclosures of the information requested to be changed under this Request for Amendment of Health Information.
- File a written complaint with the BCM Privacy Office, One Baylor Plaza, MS: 265, Houston, TX 77030
- File a written complaint with the Secretary of Health and Human Services, Office for Civil Rights.

Instructions for Completing BCM
Request for Amendment to Health Information Form

1. Print legibly in all fields using dark permanent ink. Provide as much information as possible to assist BCM in reviewing your request.

2. Sign and date the request.

3. Submit the completed and signed form to the BCM Release of Information at the address listed on the form.

4. You will receive a photocopy of your completed form, as an acknowledgment of receipt of your request, no later than 10 business days after BCM receives your request.

5. You will be notified of the acceptance or denial of your request within sixty (60) days from receipt of your request by BCM.