

Request for Change of Protected Health Information



In accordance with the Health Insurance Portability and Accountability Act (HIPAA) 1996, you have the right to request changes to your health information maintained by Baylor College of Medicine.

The Request for Change of Protected Health Information is a document that allows you to have your medical record changed upon approval of your physician.

Patient name _____ Date of birth _____

Address _____ Telephone _____

Date of entry to be changed _____

Type of entry to be changed _____

Please explain how you believe the record should be changed:

Would you like this requested change sent to anyone to whom we may have disclosed information from the HIPAA compliance date of April 14, 2003 to present? If so, please specify the name and address of the organization or individual.

Name of person or entity to whom the requested change may be disclosed:

Address of person or entity to whom the requested change may be disclosed:

Authorization granted by: (print name) _____

Relationship to patient: _____

Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of the patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan).

Signature of Patient or Legal Representative

Date

Internal Use Only:

Change: Accepted Declined

Reason Declined: _____

Signature of Health Care Provider

Date

Internal Use Only:

Patient I.D. Number: _____

____ 030 ____ 060

Patient Notified:

Process Date _____ By _____

(Initials)