Patient Name: _____

Date of Birth: _____

Medical Record #: _____

**Place Patient Label**

RUSH

# PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Rights-P
HIPAA Privacy Patient Rights

IDN13150017

**INSTRUCTIONS: As a patient, you have the right to request that Rush change or amend your protected health information in the medical record that Rush maintains. Rush may approve or not approve the request under certain circumstances.**

**Patient Information** – please provide us with the following information about the patient:

| | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| Street Address | City | State |
| Zip Code | XXX-XX- _____ Last 4 SSN | Date of Birth |
| Patient Signature | Date of Request | Phone Number |

Personal Representative – if you are the patient's personal representative, please provide your information below:

(Note: If a personal representative is making this request, please attach certifying documentation of your status as the personal representative, such as a Power of Attorney or Guardianship papers).

| | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| Personal Representative Signature | Date of Request | Relationship to Patient |

**Specify the records you wish to amend and the amendments you wish to make:**

_____ Lab results _____ Billing

_____ Treatment information _____ Other: (please explain): _____

State the reasons for the amendment request (Please attach additional comments in another page if necessary):

_____

_____

_____

_____

_____

**When completed, please return this form to:**

Rush University Medical Center, ATTN: Privacy Office, 707 South Wood St., Suite 317, Chicago, IL 60612-3833

Telephone: (312) 942-5303 • Fax: (312) 942-6875