



University of Colorado
Colorado Springs

Request for Amendment of Health Information

Instructions

To submit a request for amendment, please complete, sign and return the attached form to:

Director – (Insert Clinic Name)
UCCS HealthCircle Clinics
Lane Center for Academic Health Sciences
4863 North Nevada Ave.
Colorado Springs, CO 80918

The attached form may be used to request an amendment to a record of your medical care. We are required to amend your medical record, upon written request, unless:

- (1) we did not create the information;
- (2) we do not maintain the information as part of your record;
- (3) we determine that the information is accurate and complete as currently recorded; or
- (4) the information is the type that would not be available to you for inspection.

Please be aware that under no circumstances will we delete or alter the original documentation in the medical record. Any amendments made to the medical record will be appended in the appropriate part of the record.

If we did not create the information that you want to amend, you may submit reasonable evidence that the person or organization that originally created the information at issue is not available, and the UCCS designated healthcare competent will consider your request.

The UCCS covered entity responds to requests for amendment within sixty (60) days of receiving the written request. You may expect to receive a response or a notification of delay within that approximate time frame. If we deny your request to amend, you may submit a written statement of rebuttal, which will be included in all subsequent disclosure of the information at issue. If you choose not to submit a statement of rebuttal, a copy of this request for amendment will be included in all subsequent disclosures of that information.

For more information about amending a medical record, you may contact the UCCS HIPAA Privacy Officer at 719-255-3837, who will assist you in contacting the correct individual.

Note that requests for amendment must be made in writing and will not be accepted over the telephone.

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Today's date _____

Patient's Name _____

Medical record number if known _____

Birth Date _____

Address _____

Phone (home) _____ Phone (work) _____

Describe the information that you would like to have amended (physician notes, etc.).

On what date(s) was the care that is described in the record provided?

What is incorrect about the record? What would you like to change or add to the record?

To your knowledge, has anyone received or relied on this information (e.g. your doctor, another health care provider, and insurance company, attorney)? If yes, please provide the name(s) and address(es) of those individuals or organization so that Clinic may inform them of any amendments.

Signature: _____ Date _____

If you are not the patient, please fill in the following:

Your Name _____

Relationship to Patient _____

Address _____

Phone (home) _____ Phone (work) _____

Signature _____ Date _____