University of Colorado Colorado Springs

Request for Amendment of Medical or Billing Records 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 Health Care Components 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 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: ___________________________Social Security Number: ____________________________________
Address: ____
Phone (home): ________________________ Phone (work): ____

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

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

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

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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 HealthCircle Clinics may inform them of any amendments.

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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: _________________________