

**SOUTHEAST MISSOURI STATE UNIVERSITY**

*Please check the appropriate Health Care Component*

Self-funded Health Plan       Health Clinic       Autism Center

**REQUEST TO AMEND PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby request that \_\_\_\_\_ (name of University Health Care Clinician) of Southeast Missouri State University Health Care Component indicated above to amend my medical information in the manner set forth below [specifically describe the protected health information you wish to be amended, including the date on the record, the title of the record and the name of the person that created the record]:

I request that \_\_\_\_\_ (name of University Health Care Clinician) amend the above described medical information in the following manner [specifically describe the amendment you wish to have made]:

I am requesting this amendment because [specifically describe the reason that my medical information should be amended]:

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Description of Representative's Authority

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**FOR OFFICE USE ONLY**

\_\_\_\_\_ (name of Clinician) hereby:

\_\_\_\_\_ agrees to make the requested amendment(s) to the protected health information.

\_\_\_\_\_ denies the requested amendments to the protected health information because:

\_\_\_\_\_ the information was not created by me.

\_\_\_\_\_ the information is not part of a designated record set.

\_\_\_\_\_ the information is not available for inspection by the patient.

\_\_\_\_\_ the information is accurate and complete.

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature of Reviewing Clinician