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

_____

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