STONY BROOK UNIVERSITY HOSPITAL

PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information and the process we follow once we have received your request. To request an amendment to your records, complete and return the following request form.

PATIENT INFORMATION

Patient Name: _____
Last First MI

Date of Birth: _____

Address:
_____
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address (optional):
_____

AMENDMENT REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

What information would you like to amend?

_____
_____
_____
_____

How do you believe the information should be amended?

_____
_____
_____
_____

Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request.

_____
_____
_____
_____

If this request is granted is there an individual, other person or organization who you believe may have the un-amended information and may need the amended information? If you would like us to forward the amended information to this individual, other person or organization please provide the contact information below:

Name	_____ (individual/business/organization)	**Name**	_____ (individual/business/organization)
Mailing	_____ (street including building/suite number)	**Mailing**	_____ (street including building/suite number)
Address	_____ (City, State, Zip)	**Address**	_____ (City, State, Zip)
Business Phone	(_____) _____ (area code)	**Business Phone**	(_____) _____ (area code)

You may attach a separate page if more space is needed.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Stony Brook University Medical Center amend my health information as I have explained above.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

SEND COMPLETED FORM TO:
Correspondence Manager
Health Information Mgt Dept
Stony Brook Univ. Medical Center
Stony Brook, NY 11794-7131

For [Medical Center] Use Only: **MR#** **ENC#**

Date Received: (MO/DY/YR) ____/____/____

Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED

Patient Notified In Writing On This Date: (MO/DY/YR) ____/____/____

Name of HIM Staff Member Processing This Request: _____