

**UNC HEALTH CARE SYSTEM**  
**101 Manning Drive, Chapel Hill, NC 27514**  
**(919) 966-2336 Fax (919) 966-6295**

**REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ UNC HCS Medical Record # \_\_\_\_\_

Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # (voluntary): \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Treatment Dates: \_\_\_\_\_

Type of Entry to be amended: \_\_\_\_\_

Date of Entry to be amended: \_\_\_\_\_

Please explain how the information is incorrect or incomplete. Include the information that you feel should be included in order to make the record more accurate or complete.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this amendment request will become a part of my designated record set. I also understand that this request is subject to the review of a medical provider who will use his/her professional judgment as to whether or not my record should be amended.

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

\_\_\_\_\_  
Date

**UNC HEALTH CARE SYSTEM INTERNAL USE ONLY**

Date Received \_\_\_\_\_

Accepted

Denied

If denied, check reason for denial:

PHI was not created by UNC HCS

PHI is not part of the patient's designated record set

PHI is not available for inspection as permitted by Fed. Law

PHI is accurate and complete

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient was informed of amendment or denial

\_\_\_\_\_  
Signature/Title of Staff Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Healthcare Provider

\_\_\_\_\_  
Date