



Effective Date: April 14, 2003

Request for an Amendment to Health Information

As a patient of a health care provider office within the Columbia University Medical Center organization, you may amend inaccurate or incomplete health information about you. If you want to amend your health information, you must complete this form and return it to: **Privacy Officer, Columbia University Medical Center, 601 West 168th Street, Apt. 22, New York, N.Y. 10032.** This request applies only to the health care provider office that you indicate below. If you would like to amend information maintained by more than one office, you must complete a separate form for each office.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

Phone number: _____

Address: _____

Please specify the health care provider office that holds the information to which you are requesting an amendment

Please describe the information that you want to amend (*e.g.*, my address).

Please provide a reason to support your requested amendment.

Please explain how the information is inaccurate or incomplete.

Please state your amendment in the spaces provided below (you may attach additional information as necessary).

Signature of patient or personal representative

Date

If personal representative, authority to act on behalf of patient

For Columbia University Medical Center only:

Date of receipt of request: _____ . Time extension required? Yes
No

Decision: amend in full deny in full amend or deny in part

Date of notification of decision: _____ .

Request for attachment of information submitted: Yes No

Statement of disagreement submitted: Yes No