



COLORADO COLLEGE
1 8 7 4

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

Patient's Name _____ Telephone # _____
(please print clearly)

CC ID# _____ Date of Birth _____ Date of request _____

You have the right to request an amendment to your medical record as a patient of Boettcher Health Center, except for:

- 1) Psychotherapy notes;
- 2) Protected health information (PHI) that is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
- 3) Information that is detrimental to the health or safety of yourself or others;
- 4) Information subject to Privacy Act requirements;
- 5) Confidential information that would likely reveal the source; and
- 6) Information compiled for a legal proceedings.

Date(s) of information to be amended: _____, _____, _____, _____

Describe the information you want amended (i.e., lab results, physician notes, etc.).

What is your reason for making this request?

How is the entry incorrect, incomplete, or outdated?

What should the entry say to be more accurate or complete?

(Continue on reverse side)

If we accept your request, in whole or in part, we will make a good faith effort to inform those people or entities, including our business associates, that we believe have relied, or may have relied, on the information that was in error.

Please initial or check if you want us to inform these people or entities:

Yes, I want you to inform all people or entities that you believe have relied, or may have relied, on the information that was in error.

No, please do not inform any of these people or entities.

If we accept your request, in whole or in part, we will make a good faith effort to inform those people or entities that you identify as having received protected health information and needing the amendment. Please list those people or entities (submit an additional sheet if necessary):

| Name | Address and phone number, if known |
|-------|------------------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Your request must be processed within 60 days of the date of your request. If there will be a delay in processing your request, you will be notified of the reason for the delay and the date the information will be available, but not to exceed 90 days from the original date of request.

In the event that your request is denied, in whole or in part, you will be informed in writing. The written denial will state why the request was denied and include instructions on your right to submit a written disagreement.

By signing below, I affirm that I agree to all of the above, and that the information provided is current and correct.

Signature

Date

The patient must be provided a copy of this form at the time the request is made.

The original copy of this completed form is to be maintained in the patient's record, along with any accompanying communication and action.

If you believe your privacy rights have been violated, you may make a complaint by contacting Janet Teel, Medical Office Manager, The Colorado College, Boettcher Health Center, 1106 North Cascade Avenue, Colorado Springs, CO, 80903, (719) 389-6384; or the Secretary for the Department of Health and Human Services.