THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION
HIPAA PRIVACY MANUAL
Request for Amendment of Protected Health Information

System recognizes an individual's right to request the amendment of his or her medical information, for as long as System maintains such information in a designated record set.

System may, however, deny your request to amend medical information if any of the following applies:

- Your request is not in writing;
- Your amendment request does not include a reason to support the request;
- The medical information was not created by System, unless you can show that the person who created the information is no longer available to make the amendment;
- The medical information is not part of the information kept by or for System in a designated records set;
- The medical information is not available for your inspection; or
- The medical information is accurate and complete.

Name: _____ Daytime Phone # _____

Address: _____

DOB:_____ Benefits ID #* _____ Email address:_____

Description of the requested amendment to your medical information: _____
_____
_____
_____

Reason for making the amendment (if applicable, this should include the representation that the person who created the medical information is no longer available to make the amendment): _____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

* You can look up your UT System Benefits ID number at:
https://utdirect.utexas.edu/nlogon/sgwww/SGPNIBID.WBX

If the request is signed by a Personal Representative of the individual:

Printed name of Personal Representative: _____

Representative's authority to act for the individual: _____

If signed by a Personal Representative of the individual, please note that we must verify that you are this Individual's legal representative for purposes of filing this Request. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). As this person's representative, can you be contacted at the address, e-mail, or phone number listed above? If not, please provide your mailing address, e-mail address and phone number below:

For System Use Only

Name of person processing request for amendment: _____

Title of person processing request: _____

Date request received: _____

Deadline to grant/deny requested amendment: _____

Was there an extension of the deadline?

☐ No

☐ Yes: Reason: _____
Date written notification given: _____
New deadline to grant/deny amendment: _____

Amendment: ☐ Granted ☐ Denied Date individual notified: _____

If granted:

Date records were appended or linked to the amendment: _____
Date individual's agreement to notify recipients received: _____
Dates identified recipients were notified: _____

If denied:

Did individual submit statement of disagreement?

☐ Yes Rebuttal prepared? ☐ Yes: Notification date: _____
☐ No

☐ No Did individual request attachment of request and denial? ☐ Yes
☐ No

Records attached to medical information (check all that apply):

☐ Request for amendment
☐ Denial of the request
☐ Statement of disagreement
☐ EGI's rebuttal