



ROICOR

UNIVERSITY HOSPITAL
REQUEST AMENDMENT
TO MEDICAL RECORD
HEALTH INFORMATION
MANAGEMENT DEPARTMENT

TUH-1193, 8/10

Please complete all sections on this form.

Patient's last name _____ First name _____ MI _____

Patient's address _____

City _____ State _____ Zip _____

Home phone _____ Date of birth _____

Date of service _____

Explain how the documentation is incorrect or incomplete. Please write exactly what you think the entry should state to be accurate and complete.

If your request is accepted and the appropriate amendment is made, a copy of the amended information will be sent to anyone who has previously received this information. If there is anyone else you would like to receive this amendment, please write the name(s) and address (es) of the organization (s) or person (s):

Name _____

Address _____

Name _____

Address _____

Name _____

Signature of patient or legal representation

Date

INSTRUCTIONS FOR REQUESTING AN AMENDMENT TO YOUR MEDICAL RECORD:

You have the right to request an amendment to your medical record if you believe the information is incorrect or incomplete. The amendment would include the information that you believe is in error, and your corrections to that information.

FOR MEDICAL INFORMATION:

To request an amendment to you medical information, complete the form and give it to the Health Information Management Department (Medical Records) at University Hospital.

Mailing address:

UC HEALTH: University Hospital
ATTN: Medical Records
234 Goodman Street
Cincinnati, OH 45219-2316

Fax: 513-584-0739

Hours of operation: 8:00a.m. to 6:00p.m. Monday through Friday.

Phone: 513-584-0444

Please note for demographic information:

To change demographic information (name, date of birth, address, etc) you do not need to use this form. You may request the change by sending us a written request by fax or mail (see information above)