

University of Colorado Hospital
Attention: Privacy Officer, Box A025
12401 E. 17th Ave
Aurora, CO 80045

RECORD CORRECTION/AMENDMENT FORM

Patient Name: _____ Patient Birth Date: _____

Patient Medical Record Number: _____

Patient Address: _____

Date(s) of Entry(ies) to be Amended: _____

Reason the information is incorrect or incomplete. What should the information say? A detailed explanation may be attached.

Do you need this amendment sent to anyone to whom we may have disclosed information in the past? If so, please indicate the name(s) and address(es) of the individual(s) or organizations(s)

Signature of Patient or Legal Representative Date

Relationship

FOR UNIVERSITY OF COLORADO HOSPITAL USE ONLY:

This document is to be used for tracking purposes. A copy of the notification letter to the individual is to be attached.

Date Amendment Request Received: _____

Amendment Accepted: _____ Denied: _____

Amendment Denied Because:

_____ The Information was not created by University of Colorado Hospital
_____ The Information is not available to the patient for inspection as required by law
_____ The Information is not part of the patient's health record
_____ The Information has been determined to be accurate and complete

Signature Date

Title