UW MADISON & WI STATE LABORATORY OF HYGIENE
REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name:		Request Date:	
Street Address:		Birth Date:	
City/State/Zip:		MR/Account #:	

WHAT NEEDS TO BE AMENDED and WHY

Entry to be amended:	
Date & Author of entry:	

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete?

____ ____________________
Signature of Patient or Patient's Legal Representative Date

FOR UW/WSLH INTERNAL USE ONLY

Date received:	❑ Accepted	❑ Denied

If denied, check reason for denial:

- ❑ PHI was not created by this organization
- ❑ PHI is not available to the patient for inspection as permitted by federal law (e.g., psychotherapy notes)
- ❑ PHI is not part of patient's designated record set
- ❑ PHI is accurate and complete

Comments:

- ❑ Individual was informed of denial in writing (attach letter of communication)

____ ____________________
Signature/Title of Staff Member Date

For WSLH: Return form to:

HIPAA Privacy Coordinator; State Laboratory of Hygiene; 465 Henry Mall Room 235, Madison, WI 53706