UNC HEALTH CARE SYSTEM
2700 Wayne Memorial Hospital
Goldsboro, NC 27534
919-731-6117; fax 919-587-2978

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ UNC HCS Medical Record #____________________________

Patient DOB:_____/_____/_____Social Security # (voluntary):___________________Telephone: (____)________________

Patient Address:_________________________________City:______________________State:_____Zip Code:___________

Treatment Dates:____

Type of Entry to be amended: ____

Date of Entry to be amended: ____

Please explain how the information is incorrect or incomplete. Include the information that you feel should be included in order to make the record more accurate or complete.

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Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

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I understand that this amendment request will become a part of my designated record set. I also understand that this request is subject to the review of a medical provider who will use his/her professional judgment as to whether or not my record should be amended.

____ ______________________________

Signature of Patient or Authorized Representative Date

UNC HEALTH CARE SYSTEM INTERNAL USE ONLY

Date Received________________________________ Accepted Denied

If denied, check reason for denial:

PHI was not created by UNC HCS PHI is not part of the patient's designated record set

PHI is not available for inspection as permitted by Fed. Law PHI is accurate and complete

Comments: ____

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Patient was informed of amendment or denial

____ ______________________________

Signature/Title of Staff Member Date

____ ______________________________

Signature of Healthcare Provider Date