NYU Langone HEALTH SYSTEM

Request to Amend Protected Health Information

The Health Insurance Portability and Accountability Act ("HIPAA") gives you the right to ask for an amendment to your medical record if you feel that an entry is incorrect or incomplete. This right only applies to factual statements in the record and not to a provider's observations, inferences, or conclusions. There are times when NYU Langone may not allow your record to be changed. In those cases, the patient may have NYU Langone add a statement of disagreement prepared by the patient. This statement must be 500 words or less.

To ask for an amendment, please fill out this form and submit as indicated:

- for Tisch Hospital, NYU Lutheran Medical Center, Rusk Rehabilitation, Hospital for Joint Diseases, and other NYU Hospitals Center site records, submit to: HIM, NYU Hospitals Center, 650 First Avenue, 6th Floor, NY, NY 10016 (212-263-5490).
- For NYU Clinical Cancer Center records, submit to: HIM, NYU Clinical Cancer Center, 160 E 34th St, 10th Floor, NY, NY 10003 (212-731-5096).
- for Faculty Group Practice records, submit directly to the physician's Practice Manager.
- For Lutheran Augustana, Lutheran Certified Home Health Agency, or Community Care Organization, submit to the NYU Langone Privacy Officer, One Park Ave, 3rd Floor, NY, NY 10016 (212-404-4079).
- For Southwest Brooklyn Dental Practice, submit to: Attn: Practice Manager, 476 48th St, 3rd Floor, Brooklyn, NY 11220 (347-377-5100).
- For any other location or if you are unsure where to submit, you can submit to the Patient Relations Office, 550 1st Ave, NY, NY 10016 (212-263-6906) or the NYU Langone Privacy Officer, One Park Ave, 3rd Floor, NY, NY 10016 (212-404-4079).

Patient Name (print): _____

Patient Address_____

Phone Number: _____ Email: _____

Please indicate the location/origin of the record you wish to amend (e.g., Tisch Hospital, NYU Lutheran, Clinical Cancer Center, Faculty Group Practice, Lutheran Augustana, Lutheran Family Health Center, etc.):

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_____

Please describe how the entry is incorrect or incomplete. Please attach any documents you feel are needed to make the entry more accurate or complete.

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_____

Please give the name and address of organizations or individuals to whom you believe we may have shared this information with in the past.

_____

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_____

Signature: _____ Date:_____ Time:_____ AM/PM

(Patient or person authorized to sign)

If the person consenting is not the patient, please print name and type of authority to sign. Supporting documentation should be provided at the time of submission.

Name/Authority: _____

Note: This form should be scanned into the patient's electronic medical record.

Office Use: Received: ____/_____/_____ Completed: ____/_____/_____ Initials: _____