

THE UNIVERSITY OF TEXAS AT DALLAS
CALLIER CENTER FOR COMMUNICATION DISORDERS

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

The UT Dallas Callier Center recognizes an individual’s right to request the amendment of his or her medical information, for as long as it maintains such information in a designated record set.

We may, however, deny your request to amend medical information if any of the following applies:

- Your request is not in writing;
- Your amendment request does not include a reason to support the request;
- The medical information was not created by the Callier Center, unless you can show that the person who created the information is no longer available to make the amendment;
- The medical information is not part of the information kept by or for the Callier Center in a designated records set;
- The medical information is not available for your inspection; or
- The medical information is accurate and complete.

Name: _____ Daytime Phone # _____

Address: _____
(street) (city) (state) (zip)

DOB: _____ Email address: _____

Description of the requested amendment to your medical information: _____

Reason for making the amendment (if applicable, this should include the representation that the person who created the medical information is no longer available to make the amendment): _____

Signature: _____ Date: _____
If the request is signed by a Personal Representative of the individual:

Printed name of Personal Representative: _____

Representative's authority to act for the individual: _____

If signed by a Personal Representative of the individual, please note that verification is needed that you are this individual's legal representative for purposes of filing this Request. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc.). As this person's representative, can you be contacted at the address, e-mail, or phone number listed above? Yes No

If not, please provide your mailing address, e-mail address, and phone number:

Address: _____
(street) (city) (state) (zip)

Phone: _____ Email address: _____

For Callier Center Use Only

Name of person processing request for amendment: _____

Title of person processing request: _____

Date request received: _____

Deadline to grant/deny requested amendment: _____

Was there an extension of the deadline?

No

Yes: Reason: _____

Date written notification given: _____

New deadline to grant/deny amendment: _____

Amendment: Granted Denied Date individual notified: _____

If granted:

Date records were appended or linked to the amendment: _____

Date individual's agreement to notify recipients received: _____

Dates identified recipients were notified: _____

If denied:

Did individual submit statement of disagreement?

Yes Rebuttal prepared? Yes: Notification date: _____

Did individual request attachment of request and denial? Yes No

Records attached to medical information (check all that apply):

Request for amendment

Denial of the request

Statement of disagreement