UNIVERSITY OF SOUTHERN CALIFORNIA
REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Date: _____

Address: _____

1. Please describe what protected health information (PHI) that you want to change, and include the reasons to support your request:

   _____

   _____

2. If we decide to change the health information as requested, we will send the change to any person or organization that received the information before it was changed. Please provide those name(s) and address (es), if applicable.

   _____

   _____

Please note that USC cannot amend your PHI if:

- The information is accurate and complete
- You do not have the legal right to access the PHI you want changed
- We did not create the information, unless the covered entity that created the information is unavailable to act on your request to change it (if this is the case, please explain)
- The information you want changed is not part of your Designated Record Set (medical record, billing record and information used to make decisions about you).

USC may accept or deny your request to amend as permitted under law. If denied, you will be informed in writing of the reason for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted or denied within 60 days of receipt of this request. USC can extend the response period for up to an additional 30 days) by notifying you in writing.

_____ _____

Signature of Patient or Patient's Personal Representative Date

_____

Date Received by USC

Forward to the Health Information Management Office or the Department Clinic Manager at USC