MR#: ☐☐☐☐☐☐☐
Name of Patient:
Date of Birth:
Place Label Here

UCDAVIS HEALTH

AUTHORIZATION FOR RELEASE

Date: _____

Name: _____

Date of Birth: _____

Medical Record #: _____

Tell us the manner in which you received your health information:

☐ MyUCDAVISHEALTH
☐ Signed authorization form
☐ Other: _____

Please tell us what protected health information you want changed:

_____

_____

_____

_____

Please tell us why you want this change. You **must** give a reason:

_____

_____

_____

_____

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide.

Tell us where to send you a letter:

_____

_____

_____

_____

Give a phone number so we can call you: _____

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UC DAVIS HEALTH

AUTHORIZATION FOR RELEASE

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Tell us if there are any such persons who need the changed information:

☐ No. Initials: _____

☐ Yes. Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

We may deny your request to change your protected health information if:

1. UC Davis Health did not create the information.
2. UC Davis Health believes it to be accurate and complete.
3. You do not have the legal right to access the protected health information you wanted changed.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

If you believe your privacy rights have been violated, you may file a complaint with UC Davis Health or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a complaint with UC Davis Health, contact: Compliance Hotline: 877-384-4272. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

_____ _____

Signature of patient or representative | If representative, give relationship

When you have finished filling out this form, please send it to UC Davis Health, Attention: Health Information Management, 2315 Stockton Blvd., MRB#12, Sacramento, CA 95817, or bring it to the Health Information Management Department. Email: hs-roi@ucdavis.edu