

**Harris County Hospital District**  
**Request for Amendment of Protected Health Information**

**Patient Name:** \_\_\_\_\_

**Medical record #:** \_\_\_\_\_ **Patient Account #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone number:** (H) \_\_\_\_\_ (W) \_\_\_\_\_

Description of information to be amended:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dates of the information to be amended (date of clinic visit, date of Emergency Room visit, etc...)

\_\_\_\_\_  
\_\_\_\_\_

What is the reason for requesting amendments?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How should the records be stated, i.e., what are the requested amendments?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

***For Harris County Hospital District Use Only:***

Date Received \_\_\_\_\_

Amendment has been:  Accepted  Denied

If denied, check reason for denial:

PHI was not created by HCHD

PHI is not a part of patient's Designated Record Set

PHI is not available to the patient for inspection as required by Federal law (e.g. information used for civil action)

PHI is accurate and complete

Comments of Healthcare Practitioner (Clinician-author):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Healthcare Practitioner

\_\_\_\_\_  
Date

**Top copy:** Medical Record or Billing Record of Patient    **Second copy:** Author    **Bottom copy:** Requestor

Please send request to:

Medical Record Amendments

Attention:  
Record Custodian, HIM

2525 Holly Hall  
Houston, TX 77054

Financial Record Amendments

Attention:  
Record Custodian, Patient  
Business Services

2525 Holly Hall  
Houston, TX 77054

or call: (713) 566-6600