CREIGHTON UNIVERSITY
REQUEST TO AMEND HEALTH INFORMATION

This form must be completed and submitted to: University Privacy Officer, Creighton University, 2500 California Plaza, Omaha, NE 68178. Facsimiles are accepted at (402)280-3859. Scanned images are accepted at privacy@creighton.edu.

A. **Patient**. I am requesting that Creighton University amend the health record of the following patient:

NAME _____ **DOB** _____

ADDRESS _____ **SOCIAL SECURITY NUMBER** _____

B. **Record to Be Amended**: The department whose record is to be amended (check all that apply):

❑ Creighton Dental Clinic ❑ Creighton Pediatric Therapy ❑Creighton Specialty Pediatrics

❑ Creighton Clinic Pharmacy ❑ Creighton Therapy and Wellness

C. **Requested Amendment**. I am requesting the following amendment to the patient's health record:

_____

_____

_____

_____

D. **Purpose of Request**. The reason I am requesting this amendment:

_____

_____

E. **Recipient**. Upon making the requested amendment, I ask that Creighton University provide the amended information to the following persons/entities that received the unamended health record

Recipient Name: _____ Recipient Address: _____

Recipient Name: _____ Recipient Address: _____

F. **Acknowledgment**. By my signature below, I acknowledge the accuracy of the information provided above.

_____ _____
Signature of Patient/ Personal Representative Date

_____ _____
Representative's Relationship to Patient (if applicable) Representative's printed name