PURDUE UNIVERSITY
REQUEST OF AMENDMENT OF PROTECTED HEALTH INFORMATION
FROM AN INDIVIDUAL

Instructions:

1. **Please enter the information requested in Section 1: Patient/Employee Section and mail or fax this form to:**

   HIPAA Privacy Officer, 610 Purdue Mall, West Lafayette, IN 47907-2052
   Phone: (765) 496-9059, FAX: (765) 496-0340

2. The request will be reviewed by the Purdue University HIPAA Privacy Office and other University staff as necessary. The request form will be returned to the address specified, indicating whether the request for amendment is accepted or denied and listing any entities to whom Purdue has disclosed the individual's protected health information and who may have relied or could foreseeably rely on the information to the detriment of the individual.
3. If the amendment is approved by Purdue, please review the information provided by Purdue, sign the authorization in Section 3: and either mail or fax the form to the HIPAA Privacy Officer at the address specified on this form.
4. If the amendment is approved by Purdue, the affected entities listed on the form will be notified by Purdue University of the amendment to protected health information within 21 working days of receiving the signed form.
5. If the amendment is denied you may exercise options listed below in Section 2:.

Note: If you have any questions regarding the completion of this form or about the determination of action resulting from this request, please contact the HIPAA Privacy Officer at the address or phone listed above.

Section 1: Patient/Employee Section

Patient or Employee's Name: _____ Date of Birth: _____

Patient or Employee's Address: _____

Patient or Employee's I.D.#: _____ Phone #: _____

If requested by other than the patient or employee:

_____ _____
Printed Name Individual or Personal Representative Relationship to Individual

_____
Address to which the form should be returned

I hereby request that the employees of Purdue University amend my protected health information as described below:

_____
_____
_____

Reason for request:

_____
_____

Entities, which have received my protected health information from Purdue University and would need to receive the amendment:

Entity Name	**Street Address**	**City**	**State**	**Phone**

(OVER)

Section 2: Purdue University Staff Use Only

Date Request Received _____

☐ Modification Accepted: _____ Date_____
HIPAA Privacy Officer

Entities identified by Purdue University who have received the individual's protected health information and may have relied or could foreseeably rely on the information to the detriment of the individual:

Entity Name	**Street Address**	**City**	**State**	**Phone**

☐ Amendment Request Denied:_____ Date_____
HIPAA Privacy Officer

_____
Printed Name

Reason For Denial:

The protected health information or record that is the subject of the request:

	Was not created by the covered entity and information has not been provided that indicates the originator of the protected health information is no longer available to act on the modification.
	Is confidential and not available for access or modification.
	Is not part of the HIPAA-covered health, billing or health plan record maintained by an entity of Purdue University.
	Is accurate and complete.

If your amendment request is denied, in whole or in part, you have the right to send a written statement disagreeing with the denial of all or part of the requested amendment and the basis for the disagreement. The statement should be sent to the HIPAA Privacy Officer at the address listed at the top of this form. If you do not file a written statement disagreeing with the denial, you may send a written statement to the HIPAA Privacy Officer requesting that Purdue University and its employees provide your request for amendment, the denial and any rebuttals from the covered entity, with any future disclosures of the protected health information that is the subject of the amendment.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your health information, you may file a complaint with our HIPAA Privacy Officer at the telephone number or e-mail address shown above. You also may send a written complaint to the Secretary of the Department of Health and Human Services. Further information about how to file a complaint is available from the HIPAA Privacy Officer. We will not punish you or retaliate against you if you file a complaint about our privacy practices.

Section 3: Patient/Employee Authorization

By signing below, I authorize Purdue University and its employees to amend my protected health information as described in Section 1: of this form. I further authorize Purdue University and its employees to inform and provide the amendment specified on this form to all of the entities listed above by me and by Purdue University.

Signed _____ Date_____

_____ _____
Printed Name Individual or Personal Representative Relationship to Individual

Please sign above and mail or fax this form to the HIPAA Privacy Officer at the address specified in the "Instructions" section at the top of this form.