

### Request for Amendment of Protected Health Information

You have the right to request an amendment of your protected health information maintained by Texas Children's Hospital Integrated Delivery System (TCH IDS) if you believe the information is not accurate or complete. You must submit your request on this form. If the patient is a minor child, the legally authorized representative (e.g., parent) may request the amendment.

If your request for amendment is approved, the original documentation will not be changed or deleted. Your amendment will be appended or linked to the information that is being amended.

Please amend my (or my child's) information as follows:

A. Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Other Phone: \_\_\_\_\_

B. Texas Children's entity where information resides:

Texas Children's Hospital       Texas Children's Home Health Services  
 Texas Children's Health Plan       Texas Children's Pediatric Associates

Dates of admission or treatment: \_\_\_\_\_

Date of the entry or information to be amended (and time if known): \_\_\_\_\_

C. Type of record to be amended:

- |  |  |
|--|--|
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Operative Reports             |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Clinical/Outpatient Record    |
| <input type="checkbox"/> Consultation Reports      | Which clinic or Dr? _____                              |
| <input type="checkbox"/> Progress Reports          |  |
| <input type="checkbox"/> Radiology Reports         | <input type="checkbox"/> Billing Claim Forms           |
| <input type="checkbox"/> Laboratory Reports        | <input type="checkbox"/> Itemized Statement of Charges |
| <input type="checkbox"/> Pathology Reports         | <input type="checkbox"/> Other, specify: _____         |

Or, for mental health records (May require physician/psychologist approval):

- |  |  |
|--|--|
| <input type="checkbox"/> Psychiatric/Mental Health Records | <input type="checkbox"/> LSC/CAP Records       |
| <input type="checkbox"/> Neuropsychological Testing        | <input type="checkbox"/> Other, specify: _____ |

D. Describe what information is incomplete or incorrect and what you believe should be changed. State what information you believe should be added and/or deleted.

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E. State the reason that supports your request. Furnish copies of supporting information, if applicable.

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TCH IDS may deny your request for an amendment if it is not on this form or does not include a reason to support the request. In addition, TCH IDS may deny your request if you ask TCH IDS to amend information that: (1) was not created by TCH IDS, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of a TCH IDS designated record set, such as the medical record; (3) is not part of the information which you would be permitted to inspect and copy; or (4) TCH IDS determines to be accurate and complete. TCH IDS will respond to your request within 60 days.

I request that TCH IDS amend my (or my child's) protected health information as maintained by TCH IDS in order to correct inaccuracies or complete the information as described above. I understand that TCH IDS reserves the right to verify my identity.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

If your amendment is accepted, TCH IDS has a responsibility to notify others who are involved in your (or your child's) care and who would rely on the amended information for your (or your child's) well-being. We request that you identify any persons you believe received the related information in the past and who rely on the information to your detriment (or to your child's). By listing a person below, you authorize TCH IDS to notify them of the amendment.

Other persons to be notified about the amendment (attach additional page(s) if necessary):

Name	Street	City	State	Zip
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Name	Street	City	State	Zip
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Mail this completed form to: Privacy Office  
Texas Children's Hospital  
6621 Fannin, Houston, MC 3-4221  
Houston, TX 77030

For more information call Texas Children's Privacy Office at (832) 824-2091.