Request to Amend Protected Health Information

The Health Insurance Portability and Accountability Act (“HIPAA”) gives you the right to ask for an amendment to your medical record if you feel that an entry is incorrect or incomplete. This right only applies t factual statements in the record and not to a provider’s observations, inferences, or conclusions. There are ti when NYU Langone Health may not allow your record to be changed. In those cases, the patient may have NYU Langone Health add a statement of disagreement prepared by the patient. This statement must be 500 words or less.

To ask for an amendment, please fill out this form and submit as indicated:

- For Tisch Hospital, Rusk Rehabilitation, NYU Langone Orthopedic Hospital, and other NYU Langone Hospitalm-1.15 T(e)<g15 T(e)<r l

ns Office 150 55 th Street,

Brooklyn, NY 11220 (718-630-7314).

- To amend NYU Winthrop Hospital records, submit to Patient Relations Office, 259 First Street, Mineola, NY 11501 (516-663-2058).
- For Perlmutter Cancer Center records, submit to: HIM, Perlmutter Cancer Center, 160 E 34th St, 10th Floor, NY, NY 10003 (212-731-5096).
- For Faculty Group Practice records, submit directly to the practice location/ practice manager.
- For the Family Health Centers at NYU Langone Health or the NYU Winthrop Certified Home Health Agency, submit to the NYU Langone Health Privacy Officer, One Park Ave, 3rd Floor, NY, NY 10016 (212-404-4079).
- For Southwest Brooklyn Dental Practice, submit to: Attn: Practice Manager, 5421st Street, Brooklyn, NY 11220 (929-455-2099).
- For any other location or if you are unsure where to submit, you can submit to the Patient Relations Office, 550 1st Ave, NY, NY 10016 (212-263-6906) or the NYU Langone Health Privacy Officer, One Park Ave, 3rd Floor, NY, NY 10016 (212-404-4079).

Patient Name (please print) ____ Date of Birth: ____________________

Patient Address ____

Phone Number: _________________________________ Email: ____

Please indicate the location/origin of the record you wish to amend (e.g., Tisch Hospital, NYU Langone Hospital-Brooklyn, Cancer Center, Faculty Group Practice or Family Health Center at NYU Langone Health location, etc.):

____

____

Please describe how the entry is incorrect or incomplete. Please attach any documents you feel are needed to make the entry more accurate or complete.

____

____

____

____

____

Please give the name and address of organizations or individuals to whom you believe we may have shared this information with in the past.

____

____

____

Signature: ______________________________________ Date:__________ Time:____________ AM/PM

(Patient or person authorized to sign)

If the person consenting is not the patient, please print name and type of authority to sign.
Supporting documentation should be provided at the time of submission.

Name/Authority: ____