CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO
Student Health Center

REQUEST TO CORRECT OR AMEND HEALTH INFORMATION / MEDICAL RECORD

Coyote ID: _____

Name: _____

Date of Birth: _____

Phone Number: _____

I have identified the following health care information in my h ealth record to be inc orrect or inc omplete and request to have the information corrected or amended.

Please indicate what information is incorrect or incomplete and what the information should include to be complete and accurate on the attached page.

Date of record: _____ Provider Name/Location: _____

I understand that CSUSB Student Health Center will review my request for correction or amendment of records and respond within sixty (60) days of receipt, except in unusual circumstances. I understand that an amendment or correction is made in a manner that retains the original content but clearly indicates the amended content.

By checking this box ☐ I request to have an addendum / correction (attached) added to my medical record. I understand that in doing so, this addendum will be disclosed with all future requests for my record.

By checking this box ☐ I request that a copy of any corrected/amended be provided to me and to the persons/ entities listed below that I know to have previously received the information and could have relied upon it.

Date	Signature of patient / authorized representative	Relationship to patient if not patient

Final determination will be notified to (if **not** patient requesting):

Name: _____

Address: (Street, City, State, Zip): _____

THIS SECTION IS TO BE COMPLETED BY A STUDENT HEALTH CENTER REPRESENTATIVE AND PATIENT WILL BE NOTIFIED WITH RESPONSE OF ABOVE WITHIN SIXTY (60) DAYS.

Correction / Amendment has been: ☐ Accepted ☐ Denied

Description of correction/amendment: _____

If denied, check reason for denial:

- ☐ The existing health information is accurate and complete.
- ☐ This health information was not created by this organization.
- ☐ This request was not part of the patient's health care records.
- ☐ The record no longer exists or cannot be found.

I have reviewed this request for correction/amendment and responded with the decision indicated above.

Staff Name (printed)	Staff Signature	Date
Provider Name (printed)	Provider Signature	Date
Director Name (printed)	Director Signature	Date

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Date of Birth: _____

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I request that this addendum be made a part of my medical record. I understand that in doing so, this addendum will be disclosed with all future requests for my medical record.

Patient Signature: _____ Date: _____

Printed Name: _____

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If your request is approved/accepted by your provider, it will be added to the chart as an addendum. Nothing in the chart will be removed, erased or deleted. The addendum will identify that section of the chart is being corrected, the date, and electronically signed by persons making the corrections.

The completed form with provider determination will be uploaded into the patient chart for recored keeping.

If you have checked the asking for your written addendum to be attached to your record, and you have supplied that written addendum with this form, the addendum will be attached to your record within 10 business days of completed review by Student Health Center Staff. The addendum and request for amendment will be included in all future relevant disclosure of your information.

If you provided names and contact information for persons/entities that you wish to receive a copy of your corrected information, we will send that information within
10 business days of the final determination by your provider if the amendment is approved.

If your provider has denied your request because the existing information is a) accurate and complete, b) the information was not completed by this organization, c) the information no longer exists, cannot be found or d) is not part of your healthcare records, and you disagree with the decision, you have the following options available:

1. Request a reconsideration and appeal of the denial, and/or
2. Complete a written statement of disagreement to be placed in your medical record.

If looking to exercise either of these options, please contact us at (909) 537 - 5241.

You can complain if you feel we have violated your privacy rights by contacting Dr. Beth Jaworski at 909-537-3070 or at bjaworsk@csusb.edu.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting
http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.