

**Policy (CS 30) Amendment to Protected Health Information Approval Letter**

[DATE]

[REQUESTOR NAME]

[REQUESTOR ADDRESS]

Dear [REQUESTOR NAME],

We have conducted a careful and thorough review of the request you submitted to [NAME OF COVERED COMPONENT] on [DATE OF REQUEST] to amend your protected health information (PHI) and/or records. This letter is to notify you that the request has been approved.

Your records will be amended according to your request. We are required under the Health Insurance Portability and Accountability Act (HIPAA) to obtain your confirmation of the information that is being amended and to obtain your agreement to notify any relevant parties of the amendment. Relevant parties include:

- Persons, such as business associates, that we know have PHI that may have relied on, or could possibly rely on, such information to the detriment of the individual

We have identified the following relevant parties:

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- Persons you identify as having received PHI that need the information contained in the amendment

Please list the name, address, and phone number of any other parties that received PHI and need the information contained in the amendment:

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Please provide your consent to notify any relevant parties of the amendment to your PHI. Once we receive your agreement, we will make reasonable efforts to inform identified parties of the amendment.

Please contact me should you have any questions regarding this matter.

Sincerely,

[NAME]

[POSITION]

[NAME OF COVERED COMPONENT]



**APPROVAL CONSENT: PLEASE COMPLETE AND RETURN**

SECTION I:

Patient/Individual Name: \_\_\_\_\_

Patient/Individual Date of Birth: \_\_\_\_\_

Patient Individual Medical Record Number \_\_\_\_\_ OR SSN (Last 4 Digits) \_\_\_\_\_

Patient Individual Address: \_\_\_\_\_

\_\_\_\_\_

SECTION II:

I consent to allow the University of Pittsburgh to notify any relevant party identified within this amendment approval letter.

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

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