UNIVERSITY OF SOUTHERN CALIFORNIA
ACCEPTANCE OF REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: ________________________ Date of Birth: _______________________

Phone Number: ____________ Address: _____________________________________

Date of Amendment Request Form: _______ Date of this Acceptance Form: ________

Date Amendment Completed: ________

Your request to amend your protected health information has been accepted.

Please identify the individual/persons/organization with whom you would like us to share the amendment and sign this form below to indicate your agreement for us to share the amendment with the individual/persons/organization so identified.

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________________________________ ______________
Signature of Patient or
Patient's Personal Representative

Date