Return completed form to:
Austin Cancer Center - **Attn: Privacy Officer**
P.O. Box 2536
San Antonio, TX 78299-2536
Fax: 512-334-2702
Email**:** releaseofinfo@austincancercenters.com

REQUEST TO AMEND MY PROTECTED HEALTH INFORMATION

I, _____**,** request a change to my record(s) for my visit to

_____
[insert physician, department or clinic name]

on the following date(s) of service: _____**.**

I request the following change to be made: _____
_____
_____
_____
_____
_____

I request the change because: _____
_____
_____
_____
_____

Patient Name: _____
(first) (middle initial) (last)

Signature: _____ **Date:** _____

Address: _____
(street address)

_____
(city) (state) (zip code)

Phone: _____
(area code) (home phone number)

Medical Record #: _____

Birth Date: _____

Effective date 5/23/2017
Rev. 11/20/2019

If you are NOT the patient but are signing on behalf of the patient, please complete below

I, _____, **am the (check which applies)**
(print your name)

- ☐ **Parent with Parental Rights** *(not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- ☐ **Court Appointed Guardian**
- ☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- ☐ **Medical Power of Attorney** *(not sufficient for substance abuse records)*
- ☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- ☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- ☐ **Court Appointed Personal Representative of Deceased**

Representative's Signature: _____ **Date**: _____/_____/_____
(Required)

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

If you would like the response to be sent to a different address than you provided above, please fill in the following:

Patient/
Representative Name: _____
(first) (m. initial) (last)

Mailing Address: _____
(street address)

_____
(city) (state) (zip code)

1. I understand that my request will be considered, but may not be granted if Austin Cancer Center determines that my protected health information or record that is subject to this request:
    - Was not created by Austin Cancer Center, unless I provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
    - Is not part of my medical or billing record;
    - Would not be available for me for inspection under applicable law dealing with access to protected health information; or
    - Is accurate and complete.
2. I understand that I will receive a response within 60 days to amend or reject my request.
3. If Austin Cancer Center is unable to act on the amendment within 60 days, Austin Cancer Center may extend the time to act by no more than 30 days, provided that:
    - Austin Cancer Center sends me a written reason for the delay and the date by which Austin Cancer Center will complete its action on my request; and
    - Austin Cancer Center may have only one extension of 30 days to act on my request.