

**INDIVIDUAL'S REQUEST FOR AMENDMENT
OF PROTECTED HEALTH INFORMATION**

Name: (First/Middle/Last) _____

Address: (Street/City/State/Zip code) _____

Date of Birth: _____ Social Security number: _____

Date of Request: _____

Date of entry to be amended: _____

Type of entry to be amended: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

I understand that County reserves the right to amend the protected health information based on my request, and the original entry(ies) in the record will not be altered. This request to amend will be made a part of my permanent health care record.

Signature of Individual

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

Signature of Personal Representative

Date

Legal Authority of Personal Representative

For County Use:

Date Received _____ Accepted _____ Denied _____

If denied, check reason for denial:

_____ PHI is accurate and complete

_____ PHI was not created at this organization

_____ PHI is not part of individual's designated record set

_____ Pursuant to federal law PHI is not available to individual for inspection (e.g. psychotherapy notes)

_____ If denied, individual was informed of denial in writing

_____ If accepted, individual was informed of acceptance

Name/title of Individual processing this request:

Name _____

Title _____

